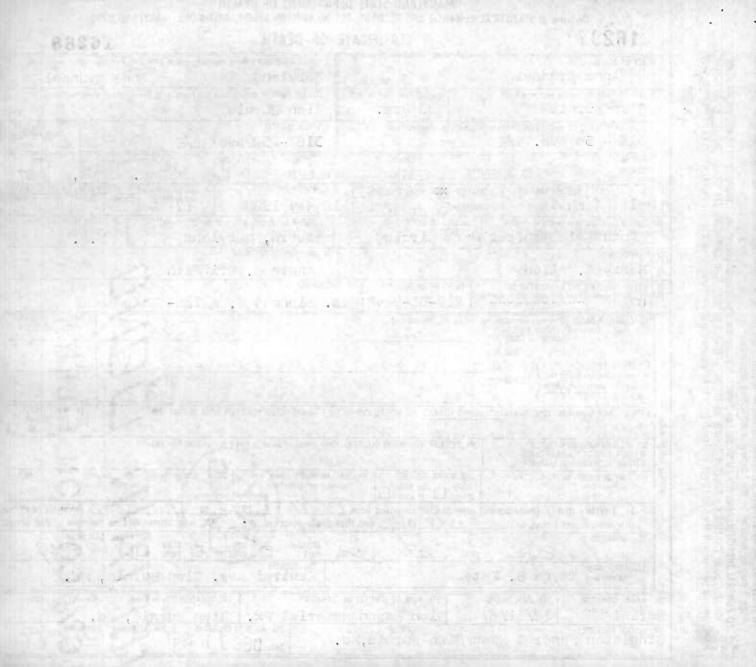
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16296 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. City OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Millersville 8 Days Millersville d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) IS RESIDENCE d. STREET ADDRESS .= ON A FARMS filled Knollwood Manor N/Home BOW #151 Rt. NO NO E YES NAME OF Middle 4 DATE Last Year remove carbon Day DECEASED 22 1967 Mr. James Albert Dec. and in ony event, (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED highday) Manths Doys Haurs White WIDOWED X DIVORCED April 24,1882 Male pup 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? **INDUSTRY** Retired Baltimore, Md. Bricklaver 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or remavol, (unknown) (unknown) Portaskiewicz IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. (Yes, na, or unknown) (If yes give war or dates of service) 216/05/6510 Steven Albert Same As (Son) None 18. CAUSE OF DEATH (Enter only one couse per line tos (a), (b), and (c).) INTERVAL BETWEEN signed by the buriol-tronsit PART 1. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital or ottending physicion. DUE TO Conditions, if ony, which gove nse ta immediate cause (a), DUE TO stating the underlying couse be detached for use as the State Dept. of Heolth prior to last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year O FUNERAL DIRECTOR: After this Hour o.m. factory, street, affice bldg., etc.) Not While at wark at wark 21. 1 certify that (1) (this hospital) attended the deceased from 19 64 ta - 196 / that (1) (we) last 1967, and that death occurred of 30 DM, from causes and an the date stated above. saw the deceased alive an DATE SIGNED 220. SIGNATURE cac .. M.D. DIRECTOR director, page should be filed Park, M 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Ray M. Smith MD Hahan Professional Bldg., Severna 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23g. BURIAL CREMATION. 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify)
Rurial Millersville, A.A.
REGISTRAR | 25b. REGISTRAR'S SIGNATURE Dec. 26.67 Our Lady of the Field Md REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS 2Sa. R.P. Ware DATE Funeral Home, Glen Aurnie, Md.

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. Division of STATISTICA	MARYLAND STATE DEP AL RESEARCH AND RECORDS, 301		TIMORE, MARYLAND 21201
16297	CERTIFICATE	OF DEATH	16288
1. PLACE OF DEATH o. COUNTY Anne Arundel	MARYLAND	Maryland	eosed lived, if institution: Residence before odmission) b. COMITY ATTURE ARUNDEL
b. CITY OR TOWN (If outside corporate limits,	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corp	orote limits, write RURAL ond give neorest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in 316 - 5th AVE. 5/E	haspital, give street oddress)	d. STREET ADDRESS B16 - 5th Ave.	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED (Type or print) CLARE		Lost 4. DAT OF DEA	TH Dec. 8, 19 67
Male White	WIDOWED DIVORCED 1	DATE OF BIRTH O May 1900	9. AGE (In yeors lost birthdoy) Months Doys Hours Min.
100. USUAL OCCUPATION (Give kind of work done during most of working life iven if refired) (ret	DB. KIND OF BUSINESS OR Park Lincle	11. BIRTHPLACE (County & Stote, o Severn, Mary	COLINTRY 2
13. FATHER'S NAME Henry E. Allen		14. MOTHER'S MAIDEN NAME Annie C. Gr:	lffith
1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) (If yes give wor or dotes of se	mical	FORMANT S. Blanche M. /	Address
1B. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: HAMEDIATE CAUSE (a).	acuti (m	gestin Hert At Leros class	
PART II. OTHER SIGNIFICANT CONDITIONS CONT	RIBUTING TO DEATH BUT NOT RELATED TO TH	TE TERMINAL DISEASE CONDITION G	IVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES \(\sum_{\text{NO}} \) YES \(\sum_{\text{NO}} \)
200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m.	20b. DESCRIBE HOW INJURY OCCURRED. (E	Enter noture of injury in Port I or	Port II of item 1B.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19		OF INJURY (Home, form, ry, street, office bldg., etc.)	f. (City or town) (County) (State)
21. I certify that (I) (this hospite saw the deceased alive an	al) attended the deceased fram	death accurred at 542	, ta $/ > - &$, 19 $ \leq 7$, that (1) (we) la $ \leq$ M, fram causes and an the date stated above
220. SIGNATURE	B. Lato DOSMO.		STAFF 22b. DATE SIGNED
	ate		. Glen Burnie, Md.
230. BURIAL, CREMATION, PREMOVAL (Specify) 12/11/6	7 Glen Haven Me	morial Pk. G	LOCATION (City or Town) (County) (Stote) Len Burnie, Md.
24, FUNERAL ORECTOR Singleton Funeral Ho	me/Glen Burnie,Md.	DATE DEC 1	STRAR 1967 Sb. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16298 CERTIFICATE OF DEATH 16289 requires that the death certificate be executed within 24 haurs after death depth the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b in by Annapolis 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) RURAL - Annapolis 10 days d. STREET ADDRESS e. IS RESIDENC ON A FARM? signed by the attending physician and campletely filled burial-transit permit. Then please remave carbon pape, burial, crematian, or removal, and in any event, within 73 Anne Arundel General Hospital Rt-5, Box-181 YES [NO 3. NAME OF Middle DATE Manth -Day Year DECEASED 19 67 December 20 ANDERSON Homer (Type or print) DEATH S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED Jast birthday) Months Days Hours WIDOWED XX Jan. 25, 1886 Male White DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRYS Delaware Council 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates af service CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INVERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) attending physician. DUE TO Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying cause has been d far use as the of Health priar ta last. WAS AUTOPSY PERFORMED? TO HOSPITAL OR ATTENDING PHYSICIAN: The I Page 4 may be retained by the haspital or atter PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) YES TY NO TO FUNERAL DIRECTOR: After this certificate 2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH be detached State Dept. of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED (City or town) 20e. PLACE OF INJURY (Hame, farm, (Caunty) (State) Haur o.m. factory, street, office bldg., etc.) at work at wark ta Dec. 20 19 67 that (1) 306) last 21. I certify that (1) (this characted) attended the deceased from . 19 saw the deceased alive an Dec. 20 1967 and that death accurred of M, from causes and on the date stated above 22a. SIGNATURE 22b. DATE SIGNED X M.D. DIRECTOR PHYS. PHYS. ADDRESS 22c. PHYSICIAN'S NAME (Type) (County) 23a. BURIAL, CREMATION, 23b./DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) REMOVAL (Specify) 24. EUNERAL DIRECTOR 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67

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1	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYI	AND
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er death. e funeral 1 and 2. er death.	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence a. STATE Md. b. COUNTY Q. G.	before admission)
aft ges aft	b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Gears Right And Stay Corporate limits, write RURAL and give nearest town)	re nearest town)
4 9 9 5	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS	D. IS RESIDENCE DN A FARM?
executed within and completely remove carbon in any event,	3. NAME OF DECEASED (Type or print) Bess Middle Grm1 gev 4. DATE OF OF DEATH. December 2	Year
ecuted nd com move c	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR last blithday) Months Days	
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rtificate ing phys Then plimoval,	13. FATHER'S NAME John Mc Farland 14. MOTHER'S MAIDEN NAME Good rich	
eath ce attend ermit.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Africe Green well, Brisi	to/, Ned.
PHYSICIAN: The law requires that the death certificate be executed within 2 the hospital or attending physician. This certificate has been signed by the attending physician and completely fill detached for use as the burial-transit permit. Then please remove carbon bate. Dept. of Health prior to burial, cremation, or removal, and in any event, within	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the DUE TO DUE TO DUE TO	RVAL BETWEEN ET AND DEATH L YEAR
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O HOSPITAL OR ATTENDING PHYSICIA Page 4 may be retained by the hospi O FUNERAL DIRECTOR: After this cerl director, page 3 should be detached should be filed with the State Dept. of	21. I certify that (I) (this hospital) attended the deceased from Lucy., 1967, to Lucy, 1967, the saw the deceased alive on 1967, and that death occurred at M, from the causes and on the date 22a. SIGNATURE M.D. ATTENDING MED. STAFF 22b. DATE SIGNATURE 12/2 22b. DAT	
TO HOSPITAL Page 4 may TO FUNERAL I director, pag should be fil	22c. PHYSICIAN'S NAME (Type) and F. Smith, MI) 22d. ADDRESS Shady Side, Md.	
Page O FU direct Shou	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY DR CREMATDRY 23d. LOCATION (City, town or county) Burial Pec. 4.1967 Friendship Chr. Cemetery Friendship A	(State)
VR A15 (4)	Burial Dec. 4,1967 Friendship Chr. Cemetery Friendship A. A. 24, FUNERAL DIRECTOR Tunual Formal Address Owings, Maryland DATE DEC 5 1967 Funeral Stranger Strange	Co. Md.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16300 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death pub PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o STATE b. COUNTY Anne Arundel MARYLAND Maryland Anne Arundel b. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARMS campletely filled Anne Arundel General Hospital pod 132 Archwood Avenue YES NO [carbon NAME OF 4. DATE Month Year DECEASED Walter ASCHE Herman December 67 (Type or print) 19 DEATH 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF LINDER 24 HRS NEVER MARRIED remove last birthdoy) Months Doys Hours and in any White Male May 30, 1899 WIDOWED DIVORCED pup 10b. KIND OF BUSINESS OR 45 11. BIRTHPLACE (County & State, or foreign country) 10a, USUAL OCCUPATION (Give kind of work dane 12. CITIZEN OF WHAT PUDUSTRYNEER GOUNT COUNTRY? Germany 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service ELIZABETH M. ASCHE INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per tipe for (g).
PART I. DEATH WAS CAUSED BY: the signed by the burial-transit burial, cremati IMMEDIATE CAUSE attending physician. Conditions, if ony, which gove rise to immediate couse (o), DUE TO has been sise as the the the prior to be stating the underlying couse nocarcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONDITIONS TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? Health NO certificate ATTENDING PHYSICIAN: 20g. ACCIDENT WAS LINDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) Dept. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detacher 20c. TIME OF INJURY Month, Doy, Year 20d INTURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m. foctory, areet, office bldg., etc.) Not While TO FUNERAL DIRECTOR: After of work at wark 21. I certify that (I) (this haspital) attended the deceased fram. be retained saw the deceased alive an_ 16 196 , and the death accurred at fram causes and an the date stated above 22o. SIGNATUR 22b. DATE SIGNED M.D. PHYS DIRECTOR director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 1407 Forest Drive, Annapolis, Md. FETER F. VERKOUD m. O NAME OF CEMETERY OR CREMAJORY 23o. BURIAL, CREMATION 23d. LOCATION (City or Town) (Stote) (County) CEM. FUNERAL DIRECTOR REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16302 CERTIFICATE OF DEATH 16294 death I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY and in any event, within 72 hours after Anne Arundel MARYLAND Maryland Anne Amundel after Pages the b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Annapolis Churchton 2 hrs. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hor d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) .⊑ papers. d. STREET ADDRESS IS RESIDENC ON A FARM? Box-36 Anne Arundel General Hospital NO X carbon NAME OF First Middle 4. DATE Last Year DECEASED William AYERS 1967 December (Type or print) DEATH 6. COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED XX DATE OF BIRTH NEVER MARRIED remove birthdoy) Months Hours White Male WIDOWED DIVORCED 1Db. KIND OF BUSINESS OR 10a. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) please during mast of warking life, even if retired) COUNTRY? IVANCE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, or removal, 17_ INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO # > permit. (Yes, no, or unknown) (If yes give war or dates at sprice 18. CAUSE OF DEATH (Enter only one cause per line for to), signed by the burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise ta immediate cause (o), DUF TO stating the underlying couse this certificate has been as the prior to WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORMED? NO 2Da, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) Haur 'a.m. factory, street, affice bldg., etc.) Nat While After at wark 21. I certify that (I) (this haspital) attended the deceased and that death accurred at/220 O FUNERAL DIRECTOR: saw the deceased alive an 1967 PM, fram causes and an the date stated above. 22a. SIGNATURE DATE SIGNED STAFF M.D. DIRECTOR PHYS. director, page 3 should be filed 22d. 22c. PHYSICIAN'S NAME (Type) Shedy Side, Md, Willard F. Smith. M.D. BURIAL CREMATION NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) 2Sq. REC'D BY REGISTRAR FUNERAL DIRECTOR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67

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	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	Item 4 Film G396 1/12/68 kk CERTIFICATE OF DEATH 16295
after death.	1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. STATE Maryland b. COUNTY Anne Arundel
nours after by the bours of hours of ho	b. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town) Glen Burnie c. CENGTH OF STAY IN Ib Glen Burnie C. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town) Glen Burnie
filled in papers, thin 72 h	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) 214 Ditty Court d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO X
ortificate be executed within 2. physician ond completely filled en please remove corbon pap oval, and in any event, within in	3. NAME OF First Middle Lost J4. DATE Month Doy Year DECEASED (Type or print) Annette M. Barnwell J4. DATE OF DEATH DECEMber 29 19 67
execute d comp emove c	S. SEX 6. COLOR OR RACE WIDOWED NEVER MARRIED DIVORCED Sept. 8, 1911 9. AGE (In yeors lost birthdoy) 56 yrs. FUNDER 1 YEAR FUNDER 24 HRS.
ate be executed withician ond completely fleose remove corbon ond in ony event, with	10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY Own Home Maryland 12c. CITIZEN OF WHAT COUNTRY? LUSA
leath certific ending physi mit. Then p	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Luther Rohrbaugh LINKHOWN Address Same as
death ottendin ermit. n, or re	(Yes, no, or or unknown) (If yes give wor or dotes of service) No None 213-20-7196 Mr. Henry J. Barnwell (husband) # 2
OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours be retained by the hospital or ottending physician. DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the 3 should be detached for use as the burial-transit permit. Then please remove corban papers—Bayed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours	IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH ONSET AND DEATH
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TO HOSPITAL OR ATTENDING Poge 4 may be retained by to FUNERAL DIRECTOR: After director, page 3 should be called with the State	21. I certify that (I) (this haspital) attended the deceased from
AL OR All or be refer to be re	220. SIGNATURE M.D. ATTENDING MED. STAFF 22b. DATE SIGNED PHYS. DIRECTOR PHYS. DIRECTOR PHYS. 22d. ADDRESS. 22c. PHYSICIAN'S 22d ADDRESS.
ro Hospital of Poge 4 moy be for Funeral Director, page should be filed	NAME (Type) 165 EDH TALER STAF history Ud. Oten Island
TO HOSPII Poge 4 m TO FUNER, director,	REMOVAL(Specify) Jan. 2,1968 Glen Haven Memorial Pk, Glen Burnie, Maryland ADDRESS 1250 RECTORY REGISTRAR 2 1250 REGISTRAR'S SIGNATURE
VR A15 (4)	Singleton Funeral Home Gen Burnie, Md. DATE JAN 2 1968 Charles Judge

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16304 16296 requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH a. countinne Arundel a. STATE b. COUNTY Anne Arundel MARYLAND Maryland c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate limits, write_RURAL and give nearest town) 0.0.A Glen Rurnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? North Arundel 1303 Heathwood Road YES NO X 3. NAME OF Middle 4. DATE First Last Month Day Year DECEASED Dec. 10 19 67 FRANCIS BELL DEATH (Type or print) 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS. S. SEX B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED birthday) Days Hours 21 May 1921 White Male WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during mast of working life, even if retired) Fisher Body .S.A. Newburg. West Va. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Tva Knott Carl Bell 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, ar unknawn) ((If yes give war or dotes af service) Mary Ann Bell(Wife) 32426021 Same as INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the ATTENDING PHYSICIAN: The law 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) detached far use of the Dept. of Health p NO Z YES a 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) be retained by the haspital 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20f. (City or tawn) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (Caunty) (State) factory, street, affice bldg., etc.) Not While of wark ot wark L 21. I certify that (1) (this haspital) attended the deceased fram Dec 10, 1967, to Dec 10, 1967, that (1) (we) last saw the deceased alive an Occ 10 1967, and that death accurred at 1 mm M, fram causes and an the date stated above. 22b. DATE SIGNED 220. SIGNATURE ATTENDING 12-11-67 Daholing DIRECTOR M.D. PHYS. 400 Crain Hwy. N.W. Glen Burnit, Md. 22c. PHYSICIAN'S Robert Dabolins, M. D. NAME (Type) director, should 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (Caunty) (State) BUTIAL (Specify) Balto. Natil. Cemetery Baltimore, Md. 12/13/67 25b. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Singleton Funeral Home/ Glen Burnie, Md. VR A15 (4) DATE OFC

MARYLAND STATE DEPARTMENT OF HEALTH

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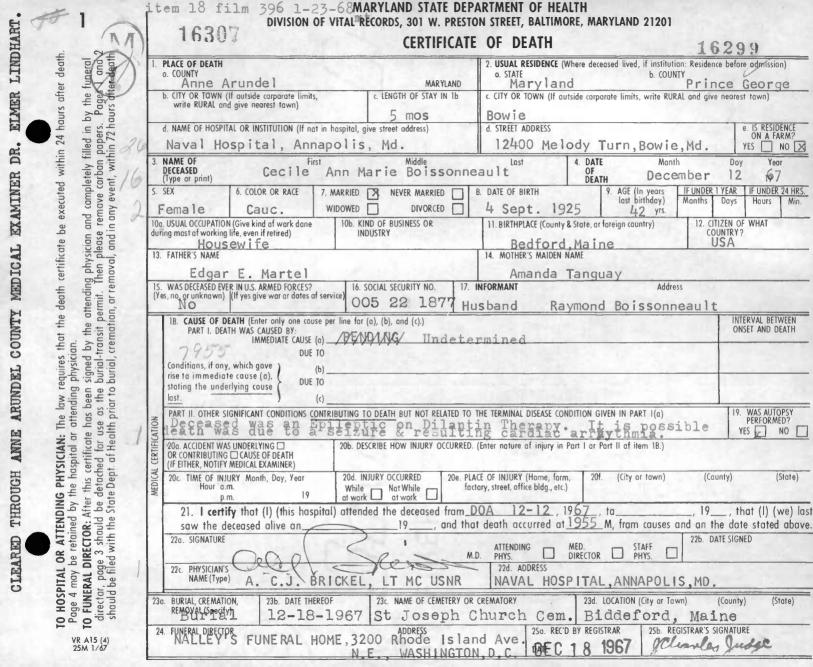
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16305 CERTIFICATE OF DEATH 16297 death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a COUNTY o. STATE b. COUNTY ANNE ARUNDET MARYLAND ANNE ARUNDEL 24 hours after b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If gutside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) DAY RURAL-GLEN BURNIE RURAL-GIEN BURNIE d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO TY 202 WICKLOW AVE FERNDALE NORTH ARUNDEL GENERAL HOSPITAL requires that the death certificate be executed within pou NAME OF First Middle Lost 4. DATE Manth Day Year DECEASED H. 19 DEATH (Type ar print) BURTON BERRY DECEMBER COL 9. AGE (In years lost birthdoy) IF LINDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH remove Months Dovs Hours any DIVORCED WIDOWED 第95×11.1892 IDo. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) COUNTRY? pleose INDUSTRY Retired Farmer NORTH CAROLINA II ISA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Evelyn W. Williamson James 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na. ar unknown) (If yes give war ar dates af service) 243-20-0738 Mrs. Alma Berry. same as 2 INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
 PART I. DEATH WAS CAUSED BY: signed by the buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) DUF TO buriol, Canditians, if any, which gave rise ta immediate couse (a). DUE TO stating the underlying cause the hospital or attending O FUNERAL DIRECTOR: After this certificate has been the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERTIFICATION NO YES OR ATTENDING PHYSICIAN: Por 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 1B.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 40 detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED (City ar tawn) (Caunty) (State) 20c. TIME OF INJURY Manth, Doy, Year 20e. PLACE OF INJURY (Hame, farm, Nat While foctory, street, affice blda., etc.) 19 67, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram___ . 19.67 to 1967, and that death accurred at 103% M, fram causes and an the date stated above. saw the deceased alive on 22b. DATE/SIGNED 22o. SIGNATURE MED. DIRECTOR M.D. PHYS. TO HOSPITAL (Page 4 may b **ADDRESS** 22c. PHYSICIAN'S NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Caunty) (Stote) 23a. BURIAL, CREMATION, REMOVAL (Specify) Swans Quarter. N. C. Soule Cemetery 20 Dec. 2Sb. REGISTRAR'S SIGNATURE 2Sq. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) Melanten DATE DEC Kirkley Funeral Home, Glen Burnie, Md. 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16308 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If autside corporate limits, c. CITY OR TOWN (It outside corparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b write RURAL and give negrest tawn) event, within 72 hours papers. = d. STREET ADDRESS IS RESIDENCE ON A FARM? in haspital, give street address) filled 06 YES NO NAME OF Middle remove carbon 4. DATE Month Last Doy Year DECEASED OF DEATH 12 19 67 S. SEX IF UNDER 24 HRS 7. MARRIED 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE NEVER MARRIED 8. DATE OF BIRTH lost birthday) Months Haurs ond in any WIDOWED DIVOR CED pup 10o. USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State or foreign country) during most of working life, even if retired INDUSTRY COUNTRY? USA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremotian, or removol. Raulen annel IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN buriol-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH be retained by the haspital or attending physician. DUE TO buriol, Conditions, if ony, which gave Homela rise to immediate cause (a), DUE TO stating the underlying cause os the of Health prior to last WAS AUTOPSY PERFORMED? hos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO YES certificote 5 20g ACCIDENT WAS LINDERLYING T 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20c. TIME OF INJURY Month. Day. Year 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) FUNERAL DIRECTOR: After this Haur o.m. Not While factory, street, office bldg., etc.) OR ATTENDING at work ot work 21. I certify that (1) (this haspital) attended the deceased fram 11/29 . 19 67, to 19 67, that (1) (we) last director, page 3 shauld should be filed with the saw the deceased alive on 12/29/67 19 , and that death accurred at 9 P _M, from causes and an the dote stoted abave. 22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. TO HOSPITAL (Poge 4 may b ADDRESS 22c. PHYSICIAN'S NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) (County) REMOVAL (Specify) mid. emeline 0 2So. REC'D BY REGISTRAR VR A15 (4) Charle

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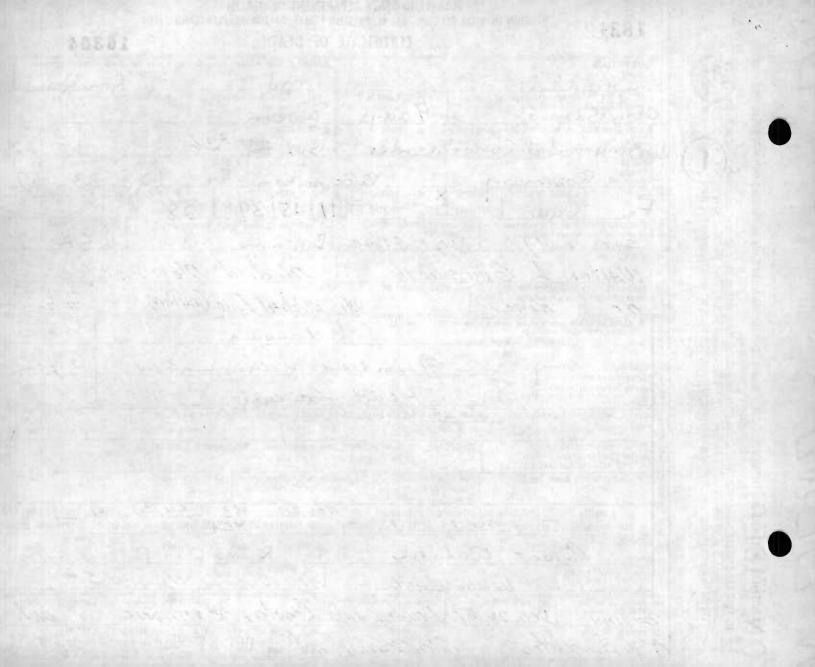
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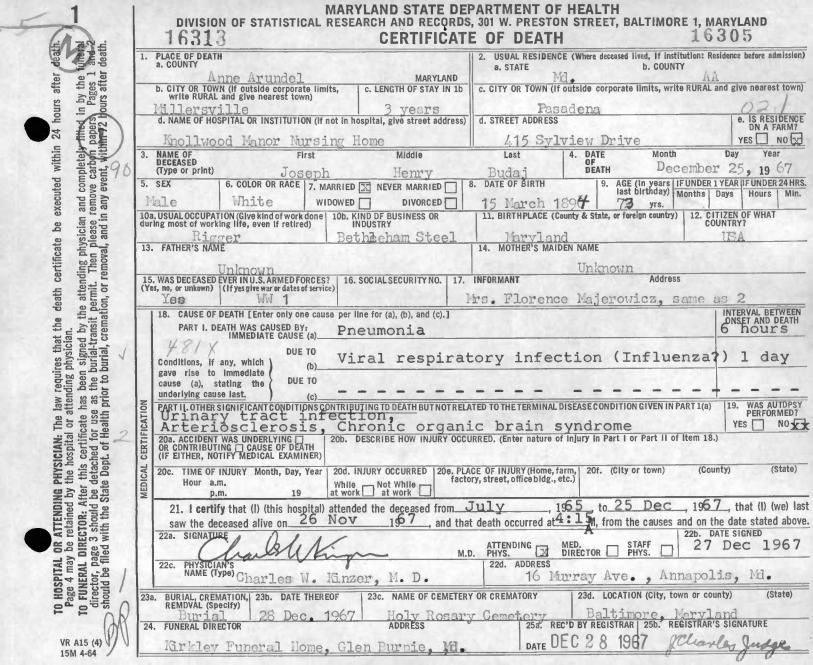
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16341 16303 CERTIFICATE OF DEATH 하 hours after death eral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND Maryland b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b Rural Freetown 18 years Rural Freetown d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Box 325 Glen Burnie P.O. Md Box 325 Glen Burnie NO 3 NAME OF Middle Last DATE Manth Day Year DECEASED (Type or print) remove corbd complete 12 24 67 NMN Brown 19 event Lenora DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years birthday) Months Haurs ond in ony WIDOWED DIVORCED 6-9-1889 Female Negro
10a. USUAL OCCUPATION (Give kind of work dane puo 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)

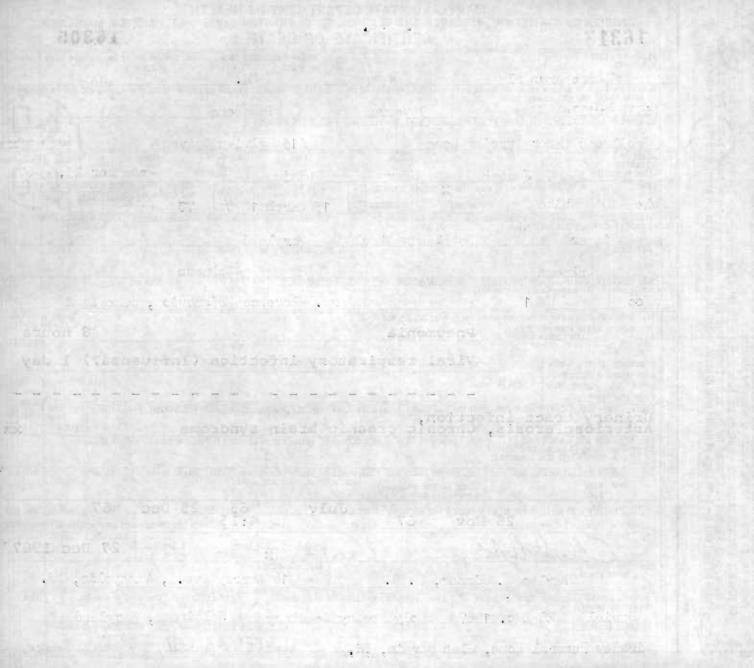
Domestic eose INDUSTRY OUNTRY? ottending physicion sermit. Then pleose Anne Arundel Co 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME buriol, cremation, or removal, Emma Curry Alfred Jerome Manns IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknawn) [(If yes give war or dates af service) 17. INFORMANT 16 SOCIAL SECURITY NO Evelyn Glenn Glen Burnie P.O.Md 217-07-0001 No *** CAUSE OF DEATH (Enter only one cause per line for (a), (b), PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (a) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Poge 4 may be retained by the hospital or attending physicion. signed b DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stating the underlying cause as the certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Health 1 NO E 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour a.m. Nat While factory, street, affice bldg., etc.) 21. I certify that (1) (this haspital) attended the deceased fram ___, that (1) (we) last TO FUNERAL DIRECTOR: saw the deceased glive an 12-15 and that death accurred aft. 30 PM, from causes and an the date stated above. 76/19 220 SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR director, page 3 >should be filed v M.D. PHYS. PHYS. **ADDRESS** 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify)
Burial Town Neck Anne Arundel Me 12-27-67 24. FUNERAL DIRECTOR ADDRESS 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 lianter Indas Annapolis, Md C.E. Hicks, 111

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16312 CERTIFICATE OF DEATH 16304 ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) Burnie Denern d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS ON A FARM? campletely filled in NO 🖂 3 NAME OF 4. DATE Lost Doy Year DECEASED (Type or print) DEATH OSEMATY SEX B. DATE OF BIRTH 9. AGE (In years JE LINDER 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months Dovs Hours WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COUNTRYS SAles 13. FATHER'S NAME 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) None burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO X **DIRECTOR:** After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office blda., etc.) Not While 21. I certify that (I) (this hospital) attended the deceased fram Nov. 29, 1963, to Die 23, 1967, that (I) (we) lost be retained Lace. 23 1967, and that death accurred of 4394M, fram couses and on the date stated above saw the deceased alive on_ 220 SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR director, page S skauld be filed 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) DAGOLINS obert 23o. BURIAL, CREMATION, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) REC'D BY REGISTRAR 24. EUNERAL DIRECTOR







DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16314 16306 CERTIFICATE OF DEATH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel Anne Arundel Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) S c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) City Annapolis 18 vrs e. IS RESIDENCE ON A FARM? YES NO d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS .⊆ ed Anne Arundel General Hospital 119 Clay Street carban ×. NAME OF Sophie First Brown Lost 4 DATE Year physician and campletely en please remave carban DECEASED BUNCH December 67 Sophia -Elizabeth-or 19 (Type or print) or-DEATH IF LINDER 1 YEAR IF UNDER 24 HRS S SFX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED Months Hours in any Female Negro January 11,1906 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? INDUSTRY Maryland Chamber maid
13. FATHER'S NAME Hotel 14. MOTHER'S MAIDEN NAME remaval signed by the attending phy burial-transit permit. Then Mary Gross Ilnknown WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Vic (Yes, no, or unknown) (If yes give wor or dotes of service 119 Clay St Annapolis 220-03-5399 Helen Dancey no burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per life for (6), (b), ond (c).)
PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) attending physician. DUE TO Conditions, if ony, which gove (b) rise to immediate couse (a). DUE TO stoting the underlying couse priar to has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED THE TERMINAL WAS AUTOPS)
PERFORMED? of Health NO X Page 4 may be retained by the haspital ar 'O FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Doy, Yeor 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work 21. I certify that (I) (this haspital) attended the deceased from 1, 1 directar, page 3 shauld shauld be filed with the M. fram causes and an the date stated above p.m 220. SIGNATURE 22b. DATE SIGNED M.D. PHYS. DIRECTOR 22c. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) 230. BURIAL, CREMATION (Stote) Burial (Specify) Brewer Hill 12-28-67 Md Annapolis 2Sb. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR DATE JAN MAnnapolis, Md C.E. Hicks, 111

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16307

1. PLACE OF DEATH	4		II 2 HSHA	I PECIDENCE (Who	are deceased lived	if institution. Posid	ence before admission)
a. COUNTY		Water and the	o. STA	ATF		b. COUNTY	/ Jefore dumission
	Anne Arundel (If autside corparate limits.	C. LENGTH OF STAY	RYLAND	Maryla		write RURAL and a	ing pages town)
CROW	and give nearest tawn)	C. LENGTH OF STAT	IN IB C. CITT O	K TOWN (II GOISIO	ue carparare iimiis,	while KUKAL and g	ive fledrest (dwif)
d. NAME OF HOS	PITAL OR INSTITUTION (If nat in	haspital, give street address)	d. STREE	T ADDRESS			e. IS RESIDENO ON A FARM
Crow	nsville State	Hospital	Rt	1 Box 5	Crownsvi	11e	YES NO
3. NAME OF DECEASED	First	Middle	L	ast 4	DATE	Month	Day Year
(Type or print)	PEARL	ANN	CARI	CO	OF DEATH D	ecember	
S. SEX	6. COLOR OR RACE 7.	MARRIED NEVER MARRI	ED B. DATE OF	BIRTH	9. AGE (Ir		R I YEAR IF UNDER 24
Female	White	WIDOWED DIVORC	ED Job	-2-19		yrs.	Doys Hours I
	ON (Give kind of work done ng life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIR	RTHPLACE (State or	foreign country)	12.	CITIZEN OF WHAT
13. FATHER'S NAME			14. MOT	HER'S MAIDEN NAM	MF /		
LAB	ne.N		HI	DA R	1EAD	-	
	EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO.	17. INFORMAN	ī		Address a=	38-8-NOW
(Yes, no, or unknown	n) (If yes give war or dotes of se	vice)	Opl	ENIA	F	Address 03	
I IB. CAUSE OF	DEATH (Enter anly one cause g	er line far (a), (b), and (c),)	CICAL	2017	-0	4110	INTERVAL BETWEE
	EATH WAS CAUSED BY: IMMEDIATE CAUSE (a).	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	nary embol	iem			ONSET AND DEAT
465X	DUE TO		J Cambo I	<u> </u>			
Canditians, if o	ny, which gove) (b)						
rise to immed	iate cause (a), (
last.	derlying couse (c)						
PART II. OTHER		RIBUTING TO DEATH BUT NOT R	ELATED TO THE TERMIN	IAL DISEASE CONDIT	TION GIVEN IN PAR	T 1(a)	19. WAS AUTOPS PERFORMED? YESTER NO
CALISE OF DEATH	CONTRIBUTING	20b. DESCRIBE HOW INJURY	OCCURRED. (Enter natu	re of injury in Par	rt I ar Part II af ite	m 1B.)	1 224
20c. TIME OF II	NJURY Manth, Doy, Yeor o.m. p.m. 19	20d. INJURY OCCURRED While Not While at wark	20e. PLACE OF INJUI factary, street,	RY (Hame, farm, office bldg., etc.)	20f. (City ar	tawn) ((Caunty) (Stot
21. 1 cert	tify that I took charge o	f the remains described (bave, held an Au	tapsyXXX,	Inspection .	Inquiry 🗍	, and in my ap
		ausesXXI Accident	, Suicide ,	Homicide	Undeterm	nined manner	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\				CHIEF MEDICAL EXA	AMINER .		
SIGNATURE	selvans 1	- Miles	M.D.	ASSISTANT MEDICA	L EXAMINER X		22. DATE SIG
EXAMINER'S -	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			DEPUTY MEDICAL E	EXAMINER		
NAME (Type)	EdwardF. Wilso	n, M.D.		Address (Street, ci	ty, town, or county) Decen	mber 2 6 , 19
230. BURIAL, CREMA	TION, 23b. DATE THERED	23c. NAME OF CE	METERY OR CREMATOR	m,	23d. LOCATION (I	City or Jown)	County A Strote
24. FUNERAL DIREC	The (193	estino	Tup)	2Sa. REC'D B		68 REGISTRARS	SIGNATURE Jacoby

DATE

VR A15ME (5)

necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB-Page

This certificate should be executed within 24 hours ofter death. If

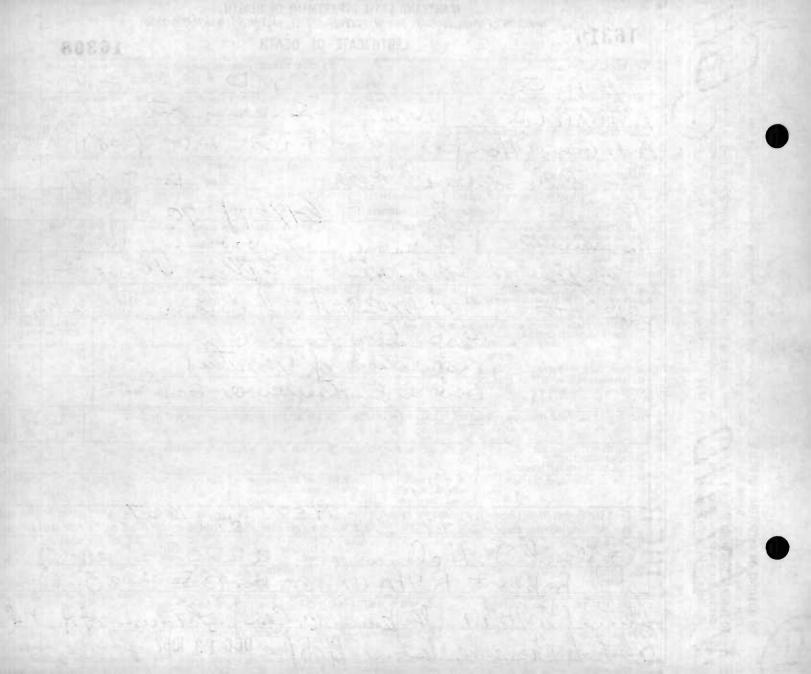
TO DEPUTY MEDICAL EXAMINER:

5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Departmen

Health prior to burial, cremotion, or removal, ond in any event within 72 hours after death.

TERMINE TO THE PROPERTY OF THE OLEGISTATION ET MILLION ÉLUL The state of the state of the state of 30 114 50 136 41.1111 Towns La Late Logical Comme LARGORN HER P. ESTE JUNE DE JUNE DE DE LA LA PROPERTIE DE LA LA PROPERTIE DE LA LA PROPERTIE DE LA PROPERTIE D COSCER RESIDENCE CONCERN ELECTRON Allen in the Market and the Market a (Mary Land Policy Colored

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16316 CERTIFICATE OF DEATH 16308 OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give_nearest town) OUIS .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If ngt in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENCE ON A FARM? filled i NAME OF Middle remove corbon event, with First Last DATE Manth Day Year completely DECEASED 0F DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years NEVER MARRIED birthday) Manths Days Hours WIDOWED DIVORCED burial, cremotion, or removol, and in any puo 10a. USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT ar fareian country) please during/most of working life, even if retired NOUSTRY Joersein 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAM attending phy permit. Then IS. WAS DECEASED EVER IN U.S. ARMED FORCES 16. SOCIAL SECURITY NO INFORMANT Address (Yes, no or unknowed (If yes give war ar dotes of service) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), PART I. DEATH WAS CAUSED BY ONSET AND DEATH burial-tronsit IMMEDIATE CAUSE (a) signed by by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise ta immediate couse (a), DUF TO stating the underlying cause os the State Dept. of Health prior to hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? NO YES FUNERAL DIRECTOR: After this certificate 5 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Caunty) (State) Hour o.m. Not While foctory, street, office bldg., etc.) ot work ot wark 21. I certify that (I) (this hospital) attended the deceased fram 19_10, to. / , 19 ___ , that (I) (we) last Page 4 moy be retoined be filed with the and that death accurred at 8 ALM, fram causes and an the date stated above. saw the deceased alive on 22a SIGNATURE 22b. DATE SIGNED M.D. PHYS DIRECTOR director, poge 22d. ADDRESS 22c. PHYSICIAN'S TO HOSPITAL NAME (Type) P.O. Box 7 should 23d. LOCATION (Citygor Tawn) BURIAL, CREMATION, NAME-OF CEMETERY OR CREMAJORY 23a. 23b. DATE THEREO (County) State) **REMOVAL** (Specify) 9 250. REC'D BY REGISTRAR
DEC 1 3 25b. REGISTRAR'S SIGNATUR FUNERAL DIRECTOR VR A15 3



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16317 CERTIFICATE OF DEATH 6309 PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death death. funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) COUNTY after MARYLAND and a b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) apers. Programme 72 mour ad. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? ean YES NO T NAME OF DECEASED Middle DATE Month Year remave carban Doy 1967 and in any event, (Type or print DEATH SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Months birthday) WIDOWED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT physician a during most of working life, even if retired) INDUSTRY COUNTRY,2, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, or remayal, attending phys 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no. or thknown) (If yes give wor or dates of service KINDENA 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse , page 3 shauld be detached far use as the be filed with the State Dept. af Health priar ta has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) TO FUNERAL DIRECTOR: After this certificate NO 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING

CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While 21. I certify that 47 (this hospital) ottended the deceased fram_ 12 1967 19<u>67</u>, that (1) (we) last 1967, and that death accurred at 4A M, fram causes and on the date stated above saw the deceased olive an 12/10 22o. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, 230 BURIAL CREMATION REMOVAL (Specify) 250. REC'D BY REGISTRAR DATHEC I 19 24. FUNERAL DIRECTOR VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16318 CERTIFICATE OF DEATH 16310 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Anne Arundel Maryland The law requires that the death certificate be executed within 24 haurs after MARYLAND Anne Arundel b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM Anne Arundel General Hospital 27 Murray Avenue NAME OF npq First 4. DATE Month Day Year DECEASED event, 67 remave car (Type or print) James Preston CHANCE DEATH December 19 S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) Months Hours and in any DIVORCED September 6.1904 WIDOWED White 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT BIRTHPLACE (County & State, or foreign country) physician on please COUNTRY? HWW APOLIS Maryland S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, (Yes, na, grunknawn) (If yes give war or dotes of service permit. MPS. JOHN GREER 18. CAUSE OF DEATH (Enter only one couse per line far (a), (b), and (c).) INTERVAL BETWEEN burial-transit throw 10515 PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) by the haspital ar attending physician. DUF TO Arterios clembi Caselal waselve Digari Conditions, if ony, which gave rise to immediate cause (a), DUE TO stoting the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? moto Anuronia **DIRECTOR:** After this certificate ye 3 shauld be detached far us 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar town) (Caunty) (State) factory, street, affice bldg., etc.) Nat While ot work at work 21. I certify that (1) (this haspital) attended the deceased from , 1967, that (1) (we) last saw the deceased alive an_ 12/7 1962, and that death occurred M, from couses and an the date stated above. 220 SIGNATURE 22b. DATE SIGNED MED. DIRECTOR ATTENDING 18/17 M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Robert Biern, M. D. 121 Cathedral St., Annapolis, Maryland. directar, 23b. DATE THEREOF 23 NAME OF PENETERY OR CREMATORY BURIAL, CREMATION 9 25M 1/67

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-	16319		CERTIFICATE				MARYL	1
1	. PLACE OF DEATH			2. USUAL RESIDENCE	7F /Wh	liana di del marto d	1001	L
	a. COUNTY	1 1		a. STATE		. COUNTY	non: Kasidenc	te batore edmission
-	b. CITY OR TOWN (if outside of	Arundel	MARYLAND		land			Arundel
1	write RURAL and give near	est town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (II	f outsida corporata lim	nits, writa RURA	AL and give n	iearast town)
1_	Annapoli	S			Annapol	lis		62-1
	d. NAME OF HOSPITAL OR IN			d. STREET ADDRESS				IS RESIDENCE ON A FARM?
-	Anne Arundel		ospital	1109 Eas	tport Terr	race		YES NO
1	NAME OF DECEASED	First	Middla	Last	4. DATE OF	Month	Day	Year
_	(Typa or print)	Earl	Fred	CHANEY 31.	DEATH -	cember	31	19 67
1	5. SEX 6. COLO	OR OR RACE 7. MARE	RIED X NEVER MARRIED B	DATE OF BIRTH	9. AGE (I	In years IF UN	NDER 1 YEAR	IF UNDER 24 HRS.
		hite WIDOW	VED DIVORCED N	lay 23, 1910	57	rinday) Moni	ihs Days	Hours Min.
F	Oa. USUAL OCCUPATION (Giva done during most of working life,	kind of work 10b.	KIND OF BUSINESS OR INDUSTR	11. BIRTHPLACE (Count	ly & State, or foreign	country) 12	2. CITIZEN OF	F WHAT COUNTRY
1	GUARD	YM	EHT YARD	AUNAPOLIS	Maryland		U	. S.
1	3. FATHER'S NAME	1		14. MOTHER'S MAIDEN				
	THOMAS	CHANIE	V	FMMA I	BROWN)			
1	5. WAS DECEASED EVER IN U.S. Yes, no, or unkown) (Ifyasgivaw		SOCIAL SECURITY NO. 17. I	NFORMANT	7.00	Address		
1	YES (1)	U TT	20 05 1671 Ma	DE BLILLE.	E CHOI	UEV .	#2	
-	18. CAUSE OF DEATH (Er	ntar only one causa pe	r line for (a), (b), and (c).]			1	INTE	ERVAL BETWEEN
	PART I. DEATH WAS CA	AUSED BY: 'E CAUSE (a)	Candina	(Proces		- 1	ONS	SET AND BEATH
	15/X	DUE TO	a	00-00.	/	0	- Cu	1
I	Conditions, if any, which	_ /	6400000	1.59	forus.	6	1	1.
	gave rise to immediate ceuse	DUE TO	ancina	a of	- cere	71	- ICU	may
	(a), stating the underlying cause last.							
1		ANT CONDITIONS CO	ONTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMIN	IAL DISEASE CONDITI	ION GIVEN IN	PART 1(a) 15	9. WAS AUTOPSY
2	PART II. OTHER SIGNIFIC						107	PERFORMED?
MOLE	PART II. OTHER SIGNIFIC							TEE TO NO FT
MOITADIS	PART II. OTHER SIGNIFIC	LYING 20h p	PESCRIBE HOW INTERPLACE LIBRE). (Enter nature of injury in	Part Lor Part II of item	n 18.1	Y	res NO 4
TED TIEL A TION	20a. ACCIDENT WAS UNDER	OF DEATH	DESCRIBE HOW INJURY OCCURRE	D. (Entar nature of injury in	Part I or Part II of itam	n 1B.)	Υ	YES NO C
AL CEPTICICATION	20a. ACCIDENT WAS UNDER CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL	OF DEATH EXAMINER)			450			
	20a. ACCIDENT WAS UNDER CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL	of DEATH EXAMINER) nth, Day, Year 20d Wh	I. INJURY OCCURRED 200, PLA		, ! 20f. (City or town		(County)	(Stata)
MEDICAL CERTICION	20s. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mon Hour s.m.	of DEATH EXAMINER) nth, Day, Year 20d Wh 19 at w	I. INJURY OCCURRED 20e, PLA ila Not Whila factor	CE OF INJURY (Home, farm	, 20f. (City or town	1)	(County)	(Stata)
	20s. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Mon Hour s.m.	of DEATH EXAMINER) nth, Day, Year 20d Wh 19 at w	i. INJURY OCCURRED 20e, PLA factork at work	CE OF INJURY (Home, farm ory, street, office bldg., etc.)	, 20f. (City or town	1)	(County)	(Stata)
	20a. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY More a.m. p.m. 21. I certify that (I) (I saw the decased alive	of DEATH EXAMINER) nth, Day, Year 20d Wh 19 at w	I. INJURY OCCURRED 20e, PLA ila Not Whila factor	CE OF INJURY (Home, farm pry, street, office bldg., etc.) Paverus Reg., death occurred at	20f. (City or lown)	2/3/,	(County)	(Stata)
	20a. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY More a.m. p.m.	of DEATH EXAMINER) nth, Day, Year 20d Wh 19 at w	i. INJURY OCCURRED 20e, PLA factork at work	CE OF INJURY (Home, farm bry, street, office bldg., etc., death occurred at	196.7. to	auses and c	(County)	(Stata) that (1) (www) late stated above
100	20a. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY More a.m. p.m. 21. I certify that (I) (I saw the deceased alive 22a. SIGNATURE	of DEATH EXAMINER) nth, Day, Year 20d Wh 19 at w	i. INJURY OCCURRED 20e, PLA factork at work	CE OF INJURY (Home, farm ory, street, office bldg., etc.) November, death occurred at ATTENDING MPHYS.	20f. (City or lown)	auses and c	(County)	(Stata) that (1) (www) late stated above
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MEDICA	20a. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Month of the control of the contr	this hospital)	I. INJURY OCCURRED 200. PLA factoric at work at work	death occurred at	196.7, to	auses and c	(County) 196. 5. the on the date	(Stata) hat (I) (we) laste stated above
T COM	20a. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY More a.m. 21. I certify that (I) (I saw the decased alive 22a. MGNAJURE (2c. PHYSICTAN'S NAME (Typa)	this hospital)	I. INJURY OCCURRED 200, PLA factor ork at work 10 st wo	death occurred at	196.7, to	auses and c	(County) 196. 5. the on the date	(Stata) hat (I) (we) la: le stated above 22b. DATE SIGNEI
W COM	20a. ACCIDENT WAS UNDER OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL 20c. TIME OF INJURY Month of the control of the contr	of DEATH EXAMINER) Inth, Day, Year 20d Wh 19 at w this hospitally after 10 m	I. INJURY OCCURRED 200, PLA factor ork at work 10 st wo	death occurred at ATTENDING PHYS. 22. 1 ATTENDING PHYS. 22. ADDRESS 16. W. W.C.	20f. (City or town) 196.7, to	auses and c	(County) 196. 5. the on the date	(Stata) hat (I) (we) la: le stated above 22b. DATE SIGNEI

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K 1 1	MARYLAND STATE DEP DIVISION OF VITAL RECORDS, 301 W. PREST		
FOR STATE	10000	CERTIFICATE OF DEATH 163	12
any delay is 7, 2, and 3 ta n PM3. Page HITPATH PAGE HITP	1. PLACE OF DEATH a. COUNTY Anne Arunde1 MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b	2. USUAL RESIDENCE (Where deceased lived, if institution: Reside a. STATE b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and gi	d. a.
If any de 11, 2, an rim PM3	write RURAL and give nearest town) Annepolis d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)	Annapolis d. STREET ADDRESS	e IS RESIDENCE ON A FARM?
after death. I. 3. Give Pages along with far with the State	196 Clay Street 3. NAME OF First Middle DECEASED (Type or print) DOROTHY Blackstone	196 Clay Street 196 Clay Street 196 Clay Street 196 COATES 196 COATES 196 COATES 196 COATES 196 COATES 196 Clay Street 196 Clay Street	VES NO
24 haurs after death. If in Item 18. Give Pages 1, er's Office along with farmes 1 and 2 with the State eafter death.	5. SEX 6. COLOR OR RACE Female Negro WIDOWED DIVORCED 100. USUAL OCCUPATION (Give kind of work done during most of working life, eyen if retized) 100. USUAL OCCUPATION (Give kind of work done during most of working life, eyen if retized)	8. DATE OF BIRTH 12 24-1936 9. AGE (In years lost birthday) 30 yrs.	R 1 YEAR IF UNDER 24 HRS Doys Hours Min. LITIZEN OF WHAT ONNTRY 2
d be executed within 24 haurs after death. If a d' "pending" in pencil in Item 18. Give Pages 1, Chief Medical Examiner's Office along with farm transit permit. File pages land 2 with the State event within 72 hours after death.	13. FATHER'S NAME ### ### ### ### ### #### ###########	INFORMANT Address OUSeuMoulden 1960	clay St
This certificate shauld be exicate, writing the ward "pend be farwarded ta the Chief M. I be used as a burial-transit p removal, and in any event wi	18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: HMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. (b) DUE TO (c)	eumonia	INTERVAL BETWEEN ONSET AND DEATH
This certificate, writible farwar	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO		19. WAS AUTOPSY PERFORMED? YES X NO
INER: ne certifi shauld files. 3 shaulc	20c. Time OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form, Cotory, street, office bldg., etc.)	ounty) (State)
exertar. Par. Par. Par. Par. Par. Par. Par. P		icide, Inspection, Inquiry, icide, Homicide, Undetermined manner [CHIEF MEDICAL EXAMINERM.D. ASSISTANT MEDICAL EXAMINER X DEPUTY MEDICAL EXAMINER	ond in my opinio
TO DEPUTY MEDI necessary, please the funeral direct 5 may be retaine TO FUNERAL DIREC	EXAMINER'S NAME (Type) 23a. BURIAL, CREMATION, PROVAL (Specify) 24. FUNERAL DIRECTOR EXAMINER'S Edward F. Wilson, M.D. 23c. NAME OF CEMETERY OR ADDRESS ADDRESS	Address (Street, city, town, or county) Decen	nber 2, 1967 (County) (Styte)
OM 1/67	William Reese + Cerma. 1	DATE DE LA 1301	V

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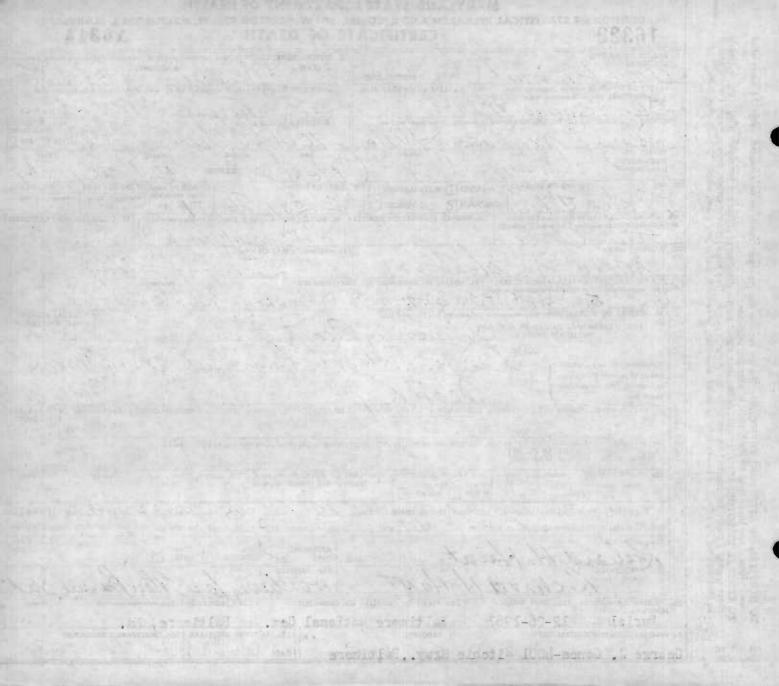
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16321 CERTIFICATE OF DEATH 16313 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY Anne Arundel b. COUNTYAnneArundel o. STATE Md . MARYLAND requires that the death certificate be executed within 24 haurs afte b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) GIT BUAL OR THE TENES HOWN) Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)

North Arundel Hospital e. IS RESIDENCE ON A FARM 3 d. STREET ADDRESS 1210 Broadview Blvd. NO + 3. NAME OF Middle 4. DATE carban First Lost Year the attending physician and completely sit permit. Then please remave carban DECEASED P. Cockerill Edgar 12-19 67 (Type or print) DEATH 9. AGE (In years los birthdoy) 6. COLOR OR RACE S. SEX 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. White Months Male 6-16-03 WIDOWED DIVORCED 1Do. USUAL OCCUPATION (Give kind of work done during post of working life even if retired) 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT INDUSTRY U COUNTRY? West Virginia Self-Employed 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Cockerill Alice Pritchard 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 215-05-4967 Patients Chart 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO K silviam - generaly YES far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dc. TIME OF INJURY Month, Doy, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour a.m Not While foctory, street, office bldg., etc.) ot work ot work 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 8</u>, 19.67, ta <u>Dec. 19</u>, 19.67 that (I) (we) last saw the deceased alive an <u>Dec. 19</u>, 19.67, and that death accurred 5:20aM, fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. Decole, 21, 1967 directar, page 3 shauld be filed w M.D. 22d. ADDRESS 22c. PHYSICIAN'S E.Roderick Shipley, M.D. Camp Meade Rd., Linthicum, Md. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Meadowridge Memorial 22 Dec. 67 256. REGISTRAR'S SIGNATURE Ellaridge. 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR Kirkley's Funeral Home, GlenBurnie, Md. Melisales VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND OF DEATH 6314 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, Il institution: Residence before admission) a. COUNTY e. STATE b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporata fimits, P c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town write RURAL and give neerast town) 2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) . STREET ADDRESS IS RESIDENCE ON A FARM? completely YES NO executed LLLoyno NAME OF First Middle DATE Month Day ba DECEASED OF within (Type or print) DEATH carbon 6. COLOR OR RACE 7. MARRIED NEVER MARRIED SEX 8. DATE OF BIRTH AGE (In years LIF UNDER 1 YEAR IF UNDER 24 HRS. and last birthday) event, Months Days Hours Min. certificate WIDOWED X DIVORCED physician remove 10a. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY W. BIRTHPLAGE (County & State, of foreign country) done during most of working life, even if retired) any 14. MOTHER'S MAIDEN NAME please .⊑ -13. FATHER'S NAME aftending and Then requires that the removal, 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address no, or unkown) | (Ifyesgive warordates of service After this certificate has been signed by the permit. the hospital or attending physician. 18. CAUSE OF DEATH [Enter only one cause per fine for (a), (b), and (c).] INTERVAL BETWEEN 6 ONSET AND DEATH PART I. DEATH WAS CAUSED BY dov cremation, IMMEDIATE CAUSE (e) burial-transit DUE TO Conditions, if any, which gave rise to immediate cause burial, DUE TO (a), stating the underlying the PHYSICIAN: causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUY NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) SE 19. WAS AUTOPSY 0 CERTIFICATION PERFORMED? use prior YES NO detached for u 20a. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be retained by ATTENDING 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour e.m. While Not While DIRECTOR: Dept. at work at work p.m. pe 21. I certify that (I) (this hospital) attended the deceased from..... plnods State M. from the causes and on the date stated above. saw the deceased alive on..19. (2...., and that death occurred at тау 22b. DATE ATTENDING SIGNED MED. STAFF HOSPITAL FUNERAL page with th PHYS. DIRECTOR PHYS. rella M.D. Page PHYSICIAN'S 22d. ADDRESS TO FUNE director, p NAME (Type) filed 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 26d. LOCATION (City, town or county) (State) REMOVAL (Specify) Baltimore National Cem. Baltimere. Burial 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE Charles an VR A15 (4) Gence-4001 Ritchie Hgwy Baltimere 20M S-63



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16315 CERTIFICATE OF DEATH 16323 The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY Anne Arundel MARYLAND Anne Arundel c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Glen Burnie Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS 705 Greentree Road 705 Greentree Road YES NOCE 3. NAME OF 4. DATE Middle Manth corbon First Last Day Year DECEASED Sophia Coliano December 30 19 67 DEATH (Type ar print) IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years 5 SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** last birthday) Manths Haurs Days WIDOWED DIVORCED /12/1898 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & State, or foreign country) COUNTRY? during most of working life, even if retired) INDUSTRY Homemaker Own Home Maruland , the ottending physici nsit permit. Then ple mation, or removol, o 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Luciano Raimondi Rose Sulvstr 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, na, ar unknawn) (If yes give war ar dates of service (Same) Angelo: Coliano INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the buriof-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: RS6102 IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause Page 4 moy be retained by the hospitol or attending O FUNERAL DIRECTOR: After this certificate hos been detoched for use as the te Dept. of Health prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO D YES -20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (Caunty) (State) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Haur a.m. factory, street, affice bldg., etc.) Nat While at work 1962 to 12.30, 196 That (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from. 12.30. 1967, and that death occurred at M. from causes and on the date stated above. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE ATTENDING DIRECTOR PHYS r, poge be filed 22d. ADDRESS 22c. PHYSICIAN'S 1101 Maiden Choice Lane Dr. Stanley Ankudas NAME (Type) director, should b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. 8URIAL, CREMATION, 23b. DATE THEREOF (County) (State) REMOVAL (Specify) Baltimore. Md. Holy Redeemer & Sons Co. 4905 York Road 21212 25b. REGISTRAR'S SIGNATURE REC'D, BY REGISTRAR 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

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	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	16324 CERTIFICATE OF DEATH
1	PLACE OF DEATH o. COUNTY o. STATE 2 1 / 2 Nd. Horse deceased lived, In Institution. Residence before edmission o. STATE 2 1 / 2 Nd. Horse HTU nde/
7	b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
50	Holly Pt. Honapolis Koads Holly Pt. Honapolis Koads VES NO NAME OF First Middle 1 Las 14 DATE Month Day Year
	OF DECEASED (Type or print) Jean M. Creighton Dec. 11 196>
	Female White WIDOWED DIVORCED Oct. 2, 1883 Styrs. Months Days Hours Min.
·	one diring most of working life, even if retired) Home Ontario, Canada USA
	Hugh Mac Kinnon 14. MOTHER'S MAIDEN HAME
l c	(If yes give were detes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT (Fraham Creighton) Address # 2
	18. CRUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate ceuse (a), stating the underlying cause last. DUE TO (c) INTERVAL BÉTWEEN ONSET AND DEATH O
CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
L CERTIFI	20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Pert II of item 18.)
MEDICAL	
	21. I certify that (I) (this hospital) attended the deceased from 112, 1960, to DEC. 12, that (I) (we) la saw the deceased alive on 2, 1960, and that death occurred at
	226. DENGLICIAN'S ATTENDING PHYS. ATTENDING PHYS. DIRECTOR PHYS. 22b. DATE SIGNE 22c. DENGLICIAN'S 22d. ADDRESS
1	NAME (TYPO) EDWARD S. BECK FRANKLIN ST. ANNADOLIS, MD. B. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER) OR CREMATORY 23d. NOCATION/(City, 194m or county) (State)
	BUTIZION 12-13-67 Cedar Grove New London Conn.
12	The M. Laylor + Sons appolis, Met. DEC 14 1967 for signature

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16317

Reg. Dist. No.

1.	PLACE OF DEATH O. COUNTY MARYLAND MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE b. COUNTY
	b. CITY OR TOWN If outside corporate limits, write RURAL c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1	Jawe	Balleneare - 304
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
2	Laurel Kage Track	702 Stamford Road YES NO
3.	NAME OF First Middle	Lost 4. DATE Month Day Year
	(Type or print) Celbert D (fin	excell DEATH 12 23 1967
5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED SE ATATEC WIDOWED DIVORCED	DATE OF BIRTH 9. AGE (In years lost birthday) 50 yrs. IFUNDER 1YEAR IF UNDER 24 HRS. Months Days Hours Min.
10	o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTR	11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY
	Salesman Chuck Wagon,	Inc. Bulto. Md. USA
13	FATHER'S NAME	14. MOTHER'S MAIDEN NAME
	Late - Albert Cummins	Late Frances Kosha
15 Y	. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN	MeIVIn Cummins Address
L	2 mm 282.18 1972 1	203 5hh Ave.
	1B. CAUSE OF DEATH [Enter only one cause per ting for (o), (b), ond (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4344 DUE TO	INTERNAL BETWEEN DISET AND DEATH
	Conditions, if ony, which gove rise to immediate cause (a), stating the underlying couse lost. (b) DUE TO	
CERTIFICATION		OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
	CAUSE OF DEATH.	ster noture of injury in Port I or Port II of item 18.)
MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLAC While Not while of work of work	E OF INJURY (Home, form, 20f. (City or town) (County) (Stote) by street, office bldg., etc.)
	21. I certify that I tack charge of the remains described above	re, held an Autapsy 🔲, Inspection 🖳 Inquiry 🖳 and find tha
	death resulted from Natural couses . Accident . Suice	ide [], Hamicide [], Undetermined cause [].
	ACTUAL SIGNATURE	M.D. CHIEF MEDICAL EXAMINER []
	EXAMINER'S NAME (Type) E-LIN band.	ASSISTANT MEDICAL EXAMINER D
22	12/21/01	National Cem. Baltimore, Md.
23	FUNERAL DIRECTOR'S SIGNATURE ADDRESS	240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
	Witzke F. D 4101 Edmondson ave.	DATE DEC 40 1001 Judge

VS. A15ME(5) 5M 9/55 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH funeral and 2 r death. hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, it institution; Residence before admission) the 1 s 1 s a. COUNTY b. COUNTY Anne Arundel MARYLAND by the Pages CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) papers. Page ARNOLD , MD Arnold. Md. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 24 NASKELL DRIVE Haskel ND P YES completely f 3. NAME OF Middle DATE Month Last Dev Year DECEASED 1967 Josephine Dameron 22 Dec. (Type or print) DEATH 5. SEX 6. COLOR OR RACE AGE (In years | IFUNDER 1 YEAR | IF UNDER 24 HRS. remove DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) F Months | Days Hours 1 any 3/16/1913 WIDOWED DIVORCED please re 1Da. USUAL OCCUPATION (Give kind of work done | 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? 13. FATHER'S NAME VA USA removal, MOTHER'S MAIDEN NAME attending ph prmit, Then Perry MANESS Pally 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) FAMILY NO 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] cremat INTERVAL BETWEEN al-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that ti Page 4 may be retained by the hospital or attending physiclan. IMMEDIATE CAUSE (a) signed burial-tr burial, **DUE TO** Conditions, if any, which (b) peen gave rise to immediate the DUE TD cause (a), stating the as th underlying cause last. CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use for use Health PERFORMED? certificate YES NO T 2Da. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Pert II of Item 18.) Page 4 may be retained to FUNERAL DIRECTOR: After this certification of the page 3 should be detached f MEDICAL 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 2De. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While While p.m. at work at work 21. I certify that (I) (this hospital) attended the deceased from Mar. 16 1904 . to Dec. 22 1967 that (I) (we) last saw the deceased alive on and that death occurred at_ _M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. DIRECTOR ADDRESS hn Professional Bldg., 22c. PHYSICIAN'S Smith. NAME (Type) m. Sever Park 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, town or county) (State) 23a. REMOVAL (Specify) 4200 Penning tonke ADDRESS 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 258. REC'D BY REGISTRAR VR AI5 (4) 2DM 1/65

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d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Anne Arundeil General Hospital 3. NAME OF DECEASED (Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED White WIDOWED DIVORCED July 18, 1903 Month Doy Month PEATH 9. AGE (In years lif Under 1 YEAR IF Under 1) Months Doys Howard Month Doy Months Death 100. USUAL OCCUPATION (Give kind of work done during mast of working life, even if retited) Selien 101. BIRTHPLACE (County & Stote, or foreign country) Selien 102. CITIZEN OF WHAT COUNTRY? Selien 103. FATHER'S NAME John Deas 104. Mother's Maiden NAME Evandeline Demas 105. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 17-32-9144 Chris Demas 18. CAUSE OF DEATH (Enter only one couse per line for (4), (b), and (c).)	unde I n) RESIDENCE A FARM? NO 19 67 NDER 24 HRS. urs Min.
o. COUNTY Anne Arunde Maryland Anne Arunde Maryland Anne Arunde Annapol is d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitol, give street oddress) Annapol is d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitol, give street oddress) Annapol is d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitol, give street oddress) Annapol is d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitol, give street oddress) Annapol is d. NAME OF DECEASED (ivpe or print) Theodore John DEMAS DEATH December 18 s. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (in yeors if UNDER I YEAR IFU Male White WIDOWED DIVORCED July 18, 1903 Gast individuoly of the yeors in the yeory of yeor	RESIDENCE A FARM? NO Year 19 67 NDER 24 HRS. urs Min.
b. CITY OR TOWN (if autside corporate limits, write RURAL and give nearest town Annapol is d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitol, give street oddress) Anne Arundel General Hospital 3. NAME OF DECCASED (I've or print) S. SEX 6. COLOR OR RACE 7. MARRIED Middle Morth DEMAS DEMAS DEMAS DEMAS DEATH P. AGE (In years just birthday) Months Doy Hondrig gast of working life even if reticed) S. SEX 10. USUAL OCCUPATION (Give kind of work done during mast of working life even if reticed) S. FATHERS NAME John Demas 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, 100, or unknown) III. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? COUNTRY? 16. SOCIAL SECURITY NO. (If yes give wor or dotes of service) 17. INFORMANT Chris Demas Conditions, if ony, which gove) (b) Conditions, if ony, which gove) (c) INTERVAL NOSE AN Annapol is Anna	RESIDENCE A FARM? NO Year 19 67 NDER 24 HRS. urs Min.
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S. SEX 6. COLOR OR RACE White Widowed Divorced July 18, 1903 Never Married	NDER 24 HRS. urs Min.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS PERF YES.	AUTOPSY ORMED?
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2Dc. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 2Dd INJURY OCCURRED While of work of two of	(Stote)
saw the deceased alive an 12 13 10 19 , and that death accurred at 12:45 M, fram/causes and an the date stored 220. SIGNATURE M.D. ATTENDING MED. STAFF 12 19 / OPEN 12 19 / O	l) (we) last ated abave.
22c. PHYSICIAN'S BEAM O CHURCH 22d. ADDRESS NAME (Type) BEAM O CHURCH 22d. DI CAFTEN NOTZ ST ANNA 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County)	0. 0
Burial Dec. 20 1967 St. Demetrius Cem. Annapolis, Anne Aru 24. FUNERAL DIRECTOR Beall Funeral Home 1212 West St. Md. Date Dec 2 1967 Clearles Yes	(Stote)Md

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #23b Film #G395-12/11/67 ab CERTIFICATE OF DEATH 16320 that the death certificate be executed within 24 haurs after death funeral 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE a. COUNTY b. COUNTY MARYLAND ges b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY DR TOWN (If autside carparate limits, write RURAL and give negrest town) write RURAL and give nearest town) Annepolis 5 3 d. STREET ADDRESS (If not in haspital, give street address) DN A FARM Southaven Rd Southber NO NO 3. NAME OF Middle 4. DATE remove carban Manth Day DECEASED Benio 12 and in any event, (Type or print) DEATH S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS last birthday) Manths Dovs WIDOWED DIVORCED 10g, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY CDUNTRY? STATE U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, Folis Im knowa 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, na, or unknown) (If yes give war ar dates of service As 2600 DIBSALIO MARS 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) by the haspital ar attending physician. DUF TO Hypertasie Arterio schools UV Misure Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) ATTENDING PHYSICIAN: The NO certificate 20o. ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED (County) DIRECTOR: After this Haur 'a.m. factory, street, affice bldg., etc.) at work 1967, to Decha, 1967 that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram June O HOSPITAL OR ATTEND Page 4 may be retained 19 67, and that death accurred at LOA M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 220 SIGNATURE M.D. DIRECTOR director, page 22d. ADDRESS 22c. PHYSICIAN'S FUNERAL NAME (Type) Robert O. Biern, M.D. 121 Cathedral Street, Annapolis, Md. 23c. NAME OF CEMETERY DR CREMATDRY 23g. BURIAL CREMATION 23b. DATE THEREDF 23d. LOCATION (City or Town) BEMOVAL (Specify) (laster leas lene ton Queen Annes M. Fineral Heme, Ronapolis mel. 24. FUNERAL DIRECTOR 2Sq. REC'D BY REGISTRAR VR A15 (4)

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- 11 /	. MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W PRESTON STREET BALTIMORE MARYLAND 21201	
	16329 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16321	Sin!
tunered I amount	1. PLACE OF DEATH 0. COUNTY MARYLAND 2. USUAL RESIDENCE, (Where deceased lived, if institution: Residence before b. COUNTY MARYLAND	admissian)
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	3. NAME OF DECEASED (Type or print) Harry Widdle Des ruy 0 DEATH 12 19	Year 1967
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ertificate be exec physicion ond co nen please remo tovol, ond in any	10o. USUAL OCCUPATION (Give kind of wark dane during most of warking life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY State Rds. Comm Severn, AA Co., Md. 12. CITIZEN DF V COUNTRY?	NHAT BA
equires that the deoth certific physician. signed by the ottending phys buriol-tronsit permit. Then p burial, cremation, or removol,	13. FATHER'S NAME George P. Disney 14. MOTHER'S MAIDEN NAME Ida E. Beasley	
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ICIAN: The law repitol or ottending rificote has been of for use os the of Heolth prior to	YES YES	VAS AUTOPSY ERFORMED? NO
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ING PH by the Iter this be deto tote De	20c. TIME DF INJURY Month, Doy, Year Rour a.m.) 20d. INJURY OCCURRED While Nat While at work	(Stote)
OR ATTENDING be retoined by th DIRECTOR: After 1 ge 3 should be d led with the Stote	21. I certify that (I) (this haspital) attended the deceased fram 10/0/17, 19-30, to 1/1/7,19, that saw the deceased dive an 17/1/6/19, and that death accurred at 8-00, fram causes and an the date 220, SIGNATURE.	stated abav
L OR A be ret DIREC DIREC	220. RHYSLEIAN'S 22d. ADDRESS 3527 PW WITHOUT 12	167
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detoched for use as the burial-tron Should be filed with the State Dept. of Health prior to burial, cre	NAME (Type) 1 S. V. QUILLE 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c., NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County)	(State)
Poge direction of the state of	REMOVAL (Specify) 22 Dec. 67 Sulphur Spring Cem. Ft. Meade, Maryla : 24. FUNERAL DIRECTOR ADDRESS ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	. ,
VR A15 (4) 25M 1/67	Kirkley Funeral Home, Glen Burnie, Md. DATOEC 2 2 1967 Yourses &	way to

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as	_1		MARYLAND STATE DEPARTMENT OF HEALTH A DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE	1 MARVIAND
-	th.		CERTIFICATE OF DEATH	16323
	deal	1.	PLACE OF BEATH a. CDUNTY Anne Arundel MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institut b. COUNTY	Ion: Residence before admission)
	s after by the Pages 1 rs after		b. CITY OR TOWN (if outside corporate limits, write RUBAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RUBAL)	URAL end give nearest town)
	hour Free Free Free Free Free Free Free Fr	-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS	D O. IS RESIDENCE ON A FARM?
	within 24 within 24		N. Arundel Convel. Center 3662 Keswick	YES ND D
	FIERE	3.	NAME OF DECEASED (Type or print) SARA CI DOWNEY DEATH 12	Day Year 28 19 67
	executed and complement complement can any event.	5.	6. COLOR OR RACE 7. MARRIED NEVER MARRIEO 8. DATE OF BIRTH 9. AGE (In years IFU Mon Mo	NDFR 1 YEAR HE LINDFR 24 HRS.
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	certificat Iding phy Then pl removal,	13	HARRY MUSGrove 14. MOTHER'S MAIDEN NAME	
	or ite	15 (Y	. WAS DECEASED BYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYND. 17. INFORMANT Address s, no for anknown) (If yes give war or dates of service)	Burne
	he de y the sit pe matio	-	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
	ires that the deat physician. I signed by the at burial-transit pern burial, cremation,		23 0X IMMEDIATE CAUSE (a) PORTO TELESTICAL ALLETTE LA	
	to e e e e e e e e e e e e e e e e e e e		gave rise to immediate cause (a), stating the DUE TO	2
		NO	underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	T1(a) 19. WAS AUTDPSY
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	the the deta	MEDICAL	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) 4	(County) (State)
	ATTENDING retained by CTOR: Afte should be vith the Sta	-	21. I certify that (I) (this hospital) attended the deceased from 1967, to 12/28/, saw the deceased alive on 12/28/, and that death occurred at 12/28/M, from the causes and	1962, that (I) (we) last
	OR ATI be ret. DIRECTI ge 3 sh ed with		223 STGNATURE ATTENDING MED. STAFF 22	
			22c. PHYSICIAN'S NAME (Type) EDMONDT, MOUSHABER 22d. ADDRESS ARLEY STATI	Med 21061
	TO HOSPITAL Page 4 may TO FUNERAL director, pa	23	REMOVAL (Specify)	or county) (State)
		2	SUNCERAL DIRECTOR APPRES SUNCERAL DIRECTOR APPRES SUNCERAL DIRECTOR APPRES SUNCERAL DIRECTOR COATE JAN 2 1968	TRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16333 CERTIFICATE OF DEATH 16325 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND after Maryland Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e. IS RESIDENCE ON A FARM? d STREET ADDRESS paper hin-72 Naval Hospital Annapolis, Md. NO X NAME OF Middle 4. DATE Lost Month carbon Year DECEASED OF DEATH DRUMM. JR. JOHN December 67 MACIA (Type or print) 9. AGE (In years lost birthday) IF UNDER I YEAR S SEX 6. COLOR OR RACE B. DATE OF BIRTH IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED Hours 26 August 1926 Male Cauc. and in any WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) NOUSTRY ATIL. GAURD BALTIMORE, MARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, ar remayal, FRANCES LOUISE CLARK NHOL DRUMM SR. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dotes of service) 216 20 0119 MRS. HILDEGARDE A. DRUMM (WIFE) SAME 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH Myocardial Infarction IMMEDIATE CAUSE (o). DUE TO Conditions, if ony, which gove Arteriosclerotic Heart Disease rise to immediate couse (a), DUE TO stoting the underlying couse as the Ventricular Fibrillation 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) this certificate has detached for use te Dept. af Health YES X NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) foctory, street, office bldg., etc.) Not While of work ot work **DIRECTOR:** After 21. I certify that (I) (this hospital) ottended the deceosed fram 10 Dec., 19 67 to 13 Dec., 1967, that (I) (we) last saw the deceased glive on 13 Dec. 19 67, and that death accurred at 1130 M, fram causes and an the date stated abave. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING X DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) COUGHLIN LT MC USNR NAVAL HOSPITAL, ANNAPOLIS, MD. director, p 230. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (County) REMOVAL (Specify) SLEN HAVEN MEMORIAL PARK GLEN BURNIE, MARYLAND 0 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE DATE DEC 19 Munten

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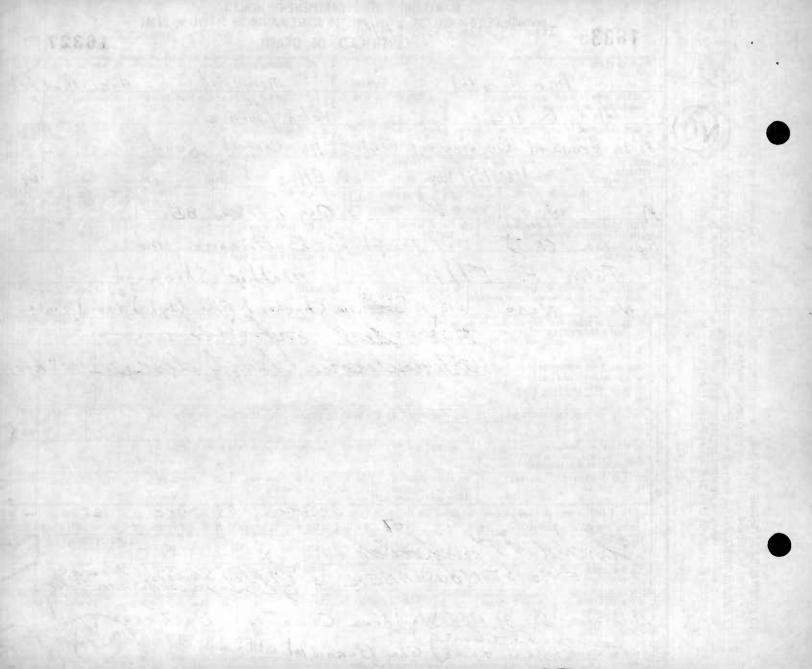
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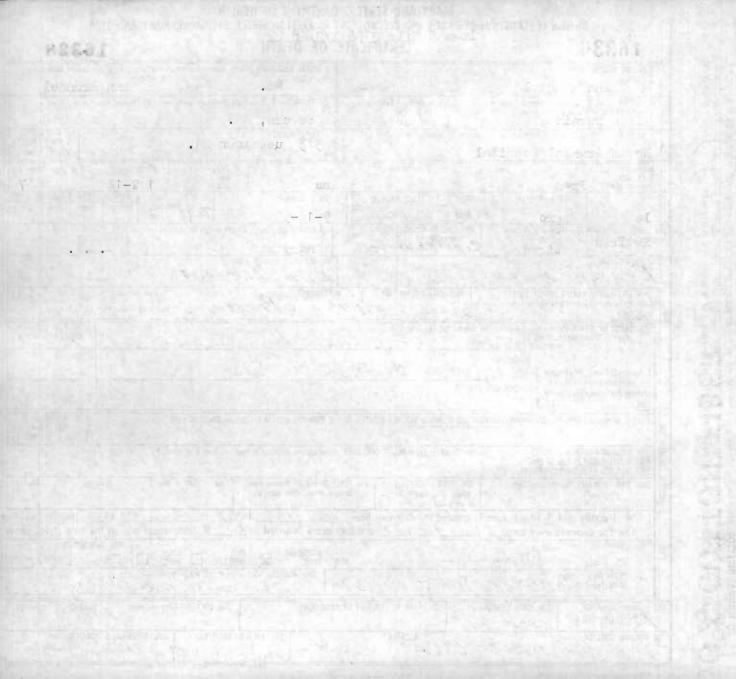
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1		DEPARTMENT OF HEALTH	21201
	16336 Item 9 Film G396 CERTIFICAT	TE OF DEATH	16328
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	Afte d by d be d be d be e Ste		21. I certify that (1) (this hospital) attended the deceased fram July 3 , 1967, to Dec. 29 , 196 saw the deceased alive an Dec. 79 1967, and that death accurred at 1254 M, from causes and an this	7, that (I) (we) last
	TOR Hould			fe date stated abave. TE SIGNED
	OR A BEC	1	Mustin Mulger M.D. PHYS. DIRECTOR DIREC	29 1967
	TO HOSPITAL (Poge 4 moy b to FUNERAL D director, poge Should be file		22c PHYSICIAN'S Morton M. Krieger, M.D. 22d ADDRESS Hammonds Lane Balto.	Md. 21225
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16339 16331 requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) 1. PLACE OF DEATH b. COUNTY Balto. Campty o. Staryland o. COUNTY Ann Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town)
Glen Burnie c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore &XXX 8 Davs Brooklyn Park) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? papers, d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) physician and campletely filled in en please remave carban paners 601 Holy Cross Rd. North Arundel Hospital YES NO X NAME OF Middle Fletcher 4. DATE Year 6 bag Walde DECEASED OF Ami) 19 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE White DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED 7 ost birthdoy) Months 5-29-94 Dovs Hours Male DIVORCED WIDOWED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired (Pipe-Fi COUNTRY? INDUSTRY West Virginia U.S.A. Railroad (Grafton) 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar remaval, Fletcher James (Unknown) the attending parisit permit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 705-03-9577 (wife) Same as Mrs. Anna M. Fletcher INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO cale Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been as the WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? USe CERTIFICATION detached far use e Dept. of Health NO far 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour a.m. Not While ot work TO HOSPITAL OR ATTENDING Page 4 may be retained by the ot work 19___, that (I) (we) last 21. 1 certify that (1) (this haspital) attended the deceased fram and that death accurred ati29 M, fram causes and an the date stated above. saw the deceased alive an. 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** STAFF M.D. DIRECTOR directar, page 3 shauld be filed v PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town) direct 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION REMOVAL (Specify) Baltimore. Md oudon Park Cemetery 250. REGISTRAR 3 725b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** 20 M 1/60 Glen Burnie, Md. Home Sinoleton Funeral DATE

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16340 CERTIFICATE OF DEATH 16332 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Anne Arundel Maryland Anne Arundel Annapolis MARYLAND b. CITY OR TOWN (If autside carporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) Arite RURAL and give nearest town) 8 yrs. HNNAPOLIS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Naval Hospital, Annapolis, Md. 702 Tyler Avenue YES NO X carbon NAME OF Middle 4. DATE Manth DECEASED Ella Fogg Mae 12 (Type ar print) DEATH 9. AGE (In years last birthday) S. SEX 6. COLOR OR RACE B. DATE OF BIRTH IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED Days OCT 8 Female Cauc. WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during prost of working life, even if retired) COUNTRY? physicion Philadelphia, Pa. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME buriol, cremation, or removol, James P. Crawford Agnes Carney 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, na, or unknown) (If yes give war ar dates af service) 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c), INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Carcinomatosis IMMEDIATE CAUSE (o). 'O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospitol or attending physicion. DUE TO Conditions, if any, which gave Carcinoma breast rise to immediate cause (o), DUE TO stating the underlying cause **DIRECTOR:** After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use detoched for use te Dept. of Heolth 20g. ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) (County) factory, street, office bldg., etc.) Nat While at wark at wark , 19___, that (I) (we) last 22a. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR director, poge 3 should be filed v M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) NAVAL HOSPITAL, ANNAPOLIS, MD. BRICKEL, LT MC USNR 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE, THEREOF 23d. LOCATION (City or Town) (County) (State) HNNA POLIS 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR **ADDRESS** 2Sq. REC'D BY REGISTRAR DATDEC 2 25M 1/67

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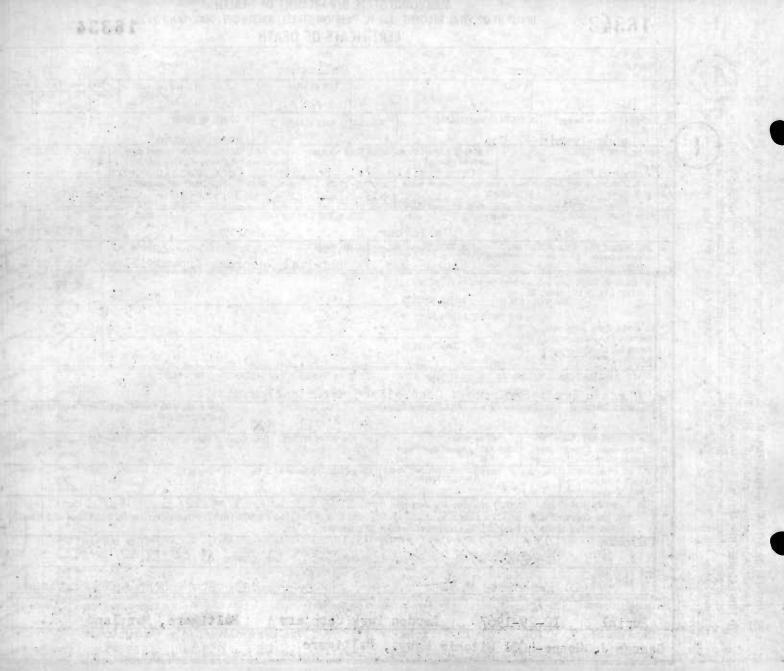
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Page 0 MACO MARYLAND delay 3 b. CITY OR TOWN (If outside corporate limits. c: LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) pup write RURAL and give nearest town) -010 - de VERNI. d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE Plum DR+ MINOR ON A FARM? Star Minor Rd. Give Pages NO X after death. 3. NAME OF First 4. DATE Manth Dov Year DECEASED he 09/eR 12 within 1967 (Type or print DEATH with 1 S. SEX 9. AGE (In years lost birthdoy) YFAR 6. CDIOR DR RACE MARRIED DATE OF BIRTH IF UNDER IF LINDER 24 HRS NEVER MARRIED tem 18. Months Dovs Hours W WIDOWED DIVDRCED June 30, 1953 haurs event 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? dny Student = pages in any School Balto. Md. II S 13. FATHER'S NAME pencil 14. MOTHER'S MAIDEN NAME certificate shauld be executed within John W. Fogler Lorraine E. Schaefer pup WAS DECEASED EVER IN U.S. ARMED EDRCES? 16. SDCIAL SECURITY ND. 17. INFORMANT permit. remayal (Yes, no, or unknown) (If yes give wor or dotes of service) Mrs. Lorraine E. Fogler No Same 1B. CAUSE OF DEATH (Enter only one couse per line for (p), (b), and (c). INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ONSELAND DEATH ar IMMEDIATE CAUSE (o) writing the ward crematian, DUE TO Conditions, if ony, which gove (b rise to immediate couse (a), DUE TO stoting the underlying couse D binrial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? please execute the certificate. YES NO M agent, prior ta 20o. EXTERNAL CAUSE WAS PRIMARY & or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 3 shauld AL EXAMINER: CAUSE OF DEATH. 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Yeor 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) While Not While foctory; street, office bldg., etc.) may be retained far your FUNERAL DIRECTOR: Page of work designated 21. I certify that Ltook charge of the remains described obove, held an Autapsy Inspection -Inquiry ond in my opinion the funeral directar. death resulted from: Natural causes Accident -Suicide | Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE O DEPUTY 0 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health NAME (Type) Address (Street, city, town, or county) DATE THEREOF 23o. BURIAL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 0 REMOVAL (Specify) 1 3 1967 Glen Haven Glen Burnie. 24. FUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR Mc Gully 130 E. Fort Ave VR A15ME (5) 1968 DATE AN 6M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16343 CERTIFICATE OF DEATH 16335 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COLINTY o. STATE b. COUNTY Anne Arundel Maryland that the death certificate be executed within 24 haurs after MARYLAND Anne Arundel b. CITY OR TOWN (If autside carparote limits, write RURAL and give nearest tawn) c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS Anne Arundel General Hospital 1 Shipwright St NO NAME OF physician and campletely f en please remave carban 4. DATE Year DECEASED (Type or print) GAY DEATH December and in any event, IF UNDER 24 HRS S. SEX NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH last birthday) Months Days Hours December 24, 1967 Male White WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT BIRTHPLACE (County & State, or foreign country) during most of working life even if retired) INDUSTRY COUNTRY? Maryland S. 14. MOTHER'S MAIDEN NAME 13. FATRER'S NAME ar remaval, 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war ar dates of service) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (g) Page 4 may be retained by the hospital ar attending physician. DUE TO Dept. of Health prior to burial, Conditions, if any, which gave rise ta immediate cause (a). DUE TO stating the underlying couse 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20g. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH etached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City ar town) (County) (State) factory, street, office bldg., etc.) TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram 19___, that (I) (we) last director, page 3 shauld M from causes and an the date stated above. saw the deceased alive an_____ and that death accurred at 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. 12-25-6 M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN 308 S. Cherry Grove Ave., Annapolis, Md. James E. Wheeler, M.D. 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 DATE DEC 29

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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		LACE OF DEATH . COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institut b. COU	ian: Residence befare admission)
1		Anne Arundel	MARYLAND	Mar	yland	H -
	b	CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If au	utside corporate limits, write RUI	RAL and give nearest town)
-		Crownsville			polis	IC DECIDENCE
	d	. NAME OF HOSPITAL OR INSTITUTION (If not in hasp		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?
6	_	Crownsville State			ge Creek Aveni	
1	C	AME OF First ECEASED	Middle	Lost	4. DATE Mont	201
-	5. 5	(ype or print) Hattie		Green	DEATH 12	2 18 1967 T IF UNDER 1 YEAR 1 IF UNDER 24 HRS.
).)	7, MARC		. DATE OF BIRTH	9. AGE (In years last builday)	Months Days Hours Min.
		F N WIDO	35-	7/29/91	76 yrs.	
		USUAL OCCUPATION (Give kind af wark dane ag mast af warking life, even if retired)	Ob. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County	& Stote, ar foreign country)	12. CITIZEN OF WHAT COUNTRY?
-		retired		Maryland		USA
П	13.	FATHER'S NAME		14. MOTHER'S MAIDEN		
		Thomas Butler		Kate (?	Butles"	
		WAS DECEASED EVER IN U.S. ARMED FORCES? , na, ar unknawn) (If yes give war or dates af service)		NFORMANT	Addre	988
		no		ospital Rec	ords, Crownsy	ille Maryland
		1B. CAUSE OF DEATH (Enter only one couse per lin	ne far (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH
		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral vascular	c accident		UNSET AND DEATH
	1	DUE TO				
	1	Canditians, if any, which gove ise to immediate cause (a), (b)	Hypertension			
		stating the underlying couse DUE 10				
			Generalized arter			
3	3	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUT	TING TO DEATH BUT NOT RELATED TO THE	HE TERMINAL DISEASE CO	NDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED?
2	3		brain syndrome			YES NO X
CLOTIC	CEKILLICATION	OR CONTRIBUTING CAUSE OF DEATH	Ob. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in	Part I or Part II of item 1B.)	
1	MEDICAL	(IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 2	Od. INJURY OCCURRED 20e. PLAC	E OF INJURY (Hame, farm	n. 20f. (City ar town)	(Caunty) (State)
New Park	MED	Hour a.m.	While Nat While facto	ry, street, office bldg., etc.)	(**************************************
	1	21. I certify that (I) (this haspital) a	ttended the deceased from]	1/18	19 67 , ta 12/ 18	, 19.67, that (I) (we) las
		saw the deceased alive an 12/1	8 1967 and that	death accurred at	1:30 M fram causes	and an the date stated above
		22g. SIGNATURE	7273	dodin decomba ar	Ci,	22b. DATE SIGNED
T		1/1/	ullilly MD.	ATTENDING PHYS.	MED. DIRECTOR STAFF PHYS.	12/18/67
	1	22c. PHYSICIAN'S		22d. ADDRESS	Difference of the second	1 12/ 10/ 01
L		NAME (Type) Ludwig, Bene			ville, State He	ospital, Maryland
1	23a	BURIAL, (REMATION, 23b. DATE THEREOF 12/21/67	234 NAME OF CEMETERY OR C	REMATORY .	280 LOCATION (City or To	wn) (County) (State)
	(Durial 12/21/67	15 roadne	CR	1 st. marg	well 4.4. nft
1	24.	FUNERAL DIRECTOR	ADDRESS ADDRESS			GISTRAR'S SIGNATURE
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral I. PLACE OF DEATH 2. USUAL RESIDENCE (Whara decessed lived, If Institution: Residence before edmission) . COUNTY b. COUNTY 170 MARYLAND and b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL end give neerest town) 10umic Mid. 070 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRES a. IS RESIDENCE ON A FARM? YES NO 3. NAME OF DATE Middle Month Dey Last Yeer DECEASED g (Type or print) DEATH and 00123 5. SEX 6. COLOR OR RACE 7. MARRIED [NEVER MARRIED DATE OF BIRTH AGE (In yeers | IF UNDER 1 YEAR IF UNDER 24 HRS. pug last birthday) Months Hours event WIDOWED [DIVORCED physician remove 10a. USUAL OCCUPATION (Give kind of work BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY 10b. KIND OF BUSINESS OR INDUSTRY | 11. done during most of working life, even if retired) Jouler please .⊑ 13. FATHER'S NAME 14. MOTHER'S-MAIDEN NAME and Then requires that the removal, 15. WAS DECEASED EVER N U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address r unkown) | (If yes give wer or detes of service) permit. aftending physician. 1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] has been signed by INTERVAL BETWEEN 6 ONSET AND DEATH PART I. DEATH WAS CAUSED BY: cremation, IMMEDIATE CAUSE (a) burial-transit DUE TO Conditions, if eny, which gave rise to Immadiate cause DUE TO (a), steting the undarlying the the hospital or ceuse lest. certificate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY prior fo CERTIFICATION PERFORMED? NO T YES | detached for 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Part I or Pert II of item 18.) DIRECTOR: After this of Health OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be retained by ATTENDING WEDICAL (State) 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20a, PLACE OF INJURY (Home, farm, 1 20f. (City or town) (County) fectory, street, offica bldg., etc.) While Not While Hour a.m. Dept. et work et work p.m. Pe 21. I certify that (I) (this hospital) attended the deceased from 10-26 1967, to 12. 20 , 1967 that (1) (we) last pinous State saw the deceased alive on. 12.20. 19.67., and that death occurred at 9.00. from the causes and on the date stated above. 22. SIGNATURE 22Ь. DATE ATTENDING MED. SIGNED HOSPITAL FUNERAL page with th PHYS. DIRECTOR PHYS. M.D. PHYSICIAN'S 22d. ADDRESS NAME (Type) ector, filed 236. LOCATION (City, BURIAL, CREMATION 23b. OR CREMATORY 23c. NAME OF CEMETERY 0 ADDRESS VR A15

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16339 16347 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY Anne Arundel Anne Arundel requires that the death certificate be executed within 24 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Bristol 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e. IS RESIDENC ON A FARM Rt-416 Anne Arundel General Hospital □ NO NAME OF Middle 4. DATE First Yeor DECEASED (Type or print) 1967 OF DEATH HALL, Sr. December Edward Frank IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED birthday) Months Hours April 1, 1895 Male Negro WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 1Do. USUAK OCCUPATION (Give kind of work done IDb. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY COUNTRY? attending physician permit. Then please arme Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar remaval 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, to, or onknown) I(If yes give wor or dates of service) INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART 1. DEATH WAS CAUSED BY: ONSET AND DEATH signed by 1 IMMEDIATE CAUSE (o' DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying couse attending PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 38.) 20o. ACCIDENT WAS UNDERLYING by the hospital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year TO FUNERAL DIRECTOR: After this foctory, street, office bldg., etc.) Hour o.m. Not While 21. I certify that (1) (Constant of the deceased fram. 19 6 to Dec. 28 , 1967, that (1) (Not last be retained sow the deceased alive on Dec. 28 19 67, and that death occurred at M, fram couses and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Charles H. Wirth, M.D. Portland Place, Lothian, Md. (County) REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR **FUNERAL DIRECTOR**

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16348 CERTIFICATE OF DEATH 16340 requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, Anne Arundel by the c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) haurs d. STREET ADDRESS Annapolis
d. NAME OF AOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) filled in IS RESIDENCE ON A FARM? 916 Central NO D within 916 Centrel 3. NAME OF Middle or Lost 4. DATE First Month carban Doy Year DECEASED Harrod 67 December 10 (Type or print) William Harris DEATH 19 NMN 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours and in any WIDOWED DIVORCED 2-21-1881 Male Negro

10o. USUAL OCCUPATION (Give kind of work done 86 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? attending physician termit. Then please Academy Anne Arundel. Md Naval Cook 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, Sarah J. Reid Wesley Harris Address Annapolis. Md WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 220-24-8169 Mary E.Swann Harris 916 Central No **** IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) be retained by the haspital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse has been the SD WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? NO X O FUNERAL DIRECTOR: After this certificate ATTENDING PHYSICIAN: 10 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18. 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While 21. I certify that (1) (this hassital) attended the deceased from SEPT. 28, 1967, to DEC. 10, 1962, that (1) (w) last directar, page 3 shauld shauld be filed with the saw the deceased alive an DEC. 1967, and that death occurred of 752M, from causes and on the date stated obove. 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR STAFF PHYS. ATTENDING M.D PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) RICHARD 20 DEAN STREET. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify)
Burial A.A.Co Md 12-13-67 Brewer Hill Annapolis 1967 FEGISTRAR'S SIGNATUR 24. FUNERAL DIRECTOR RECID BY REGISTRAR. VR A15 (4) 25M 1/67 C.E. Hicks, 111 Annapolis, Maryland

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give negrest town) Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Anne Arundel General Hospital 146 Monticello Ave.. NO XX 3. NAME OF First Middle 4. DATE Lost Doy Year DECEASED OF DEATH HERRON James Robert 20 19 67 and in any event, December (Type or print) S. SEX 6. COLOR OR RACE 9. AGE (In years 7. MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. NEVER MARRIED lost birthdoy) Months Dovs Hours White Male WIDOWED DIVORCED June 3. 1898 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT attending physician permit. Then please INDUSTRY COUNTRY? North Carolina FATHER'S NAME ar removal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT/ permit. (Yes, no, or unknown) (If yes give wor, or dollar of service) crematian, 18/ CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) physician. DUE TO signed Conditions, if ony, which gove rise to immediate couse (a), DUF TO stoting the underlying couse by the haspital ar attending has been the si howa of Recyw COS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS!
PERFORMED? YES XX NO **DIRECTOR:** After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING TI OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year (City or town) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Not While foctory, street, office bldg., etc.) 21. I certify that (I) (this characteristic attended the deceased from Nov. 15, 1967, ta Dec. 20, 1967, that (I) 100 last be retained saw the deceased alive an Dec. 20 1967, and that death accurred at M, from couses and on the date stated obave. 22o. SIGNATURE 22b. DATE SIGNED 2-20-6 M.D. DIRECTOR PHYS. PHYS. 22d ADDRESS 22c. PHYSICIAN'S O FUNERAL NAME (Type) 121 Cathedral St., Annapolis, Md. Merton T. Waite, M.D. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 23b. DATE THEREOF (Stote) 100 FUNERAL DIRECTOR 2So. REC'D BY 2Sb. REGISTRAR'S SIGNATUR VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH

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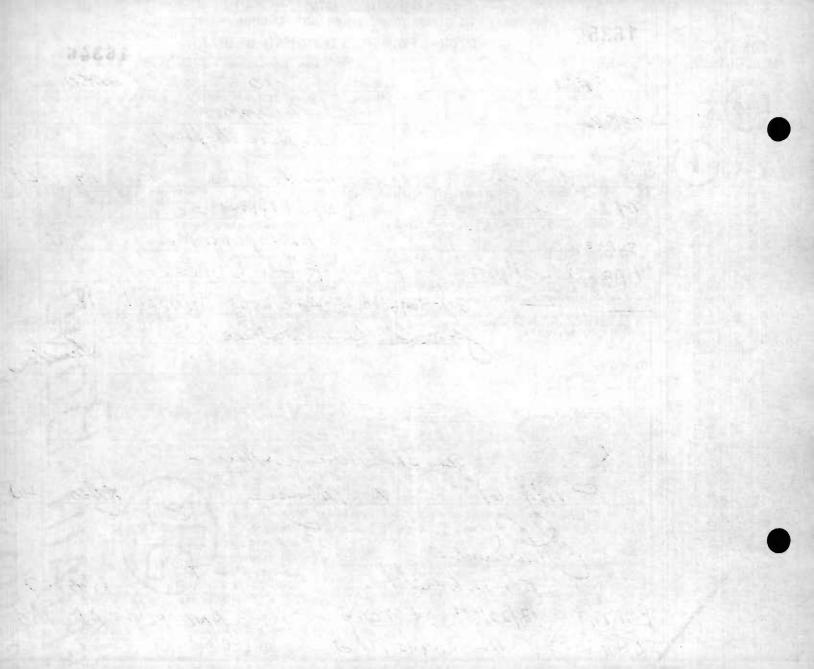
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	death.		LACE OF DEATH		lived, if institution: Residence before admission)
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	ha in 22 ho		NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
	n 24 illed pape pape in 7	1	of anusel Coursescent Center	47 Cathedral	YES NO
	equires that the death certificate be executed within 24 physician. signed by the attending physician and completely filled in burial-transit permit. Then please remave carban paper burial, crematian, ar remaval, and in any event, within 72	3.	IAME OF ECCASED Yogo or print) MATTIE Middle	HOLT 4. DATE OF DEATH	Dec 1/ 19
	cuted ompli	S.	The state of the s	B. DATE OF BIRTH 9.	AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Nost bighthdoy) Months Doys Hours Min.
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	tifica thysic n ple val, c	13.	FATHER'S MAME	14. MOTHER'S MAIDEN NAME	a LIDE
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	attending permit. The	(Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (If yes give war ar dates of service)	Leroy Evan	so Connama
	the a	Г	1B. CAUSE OF DEATH (Enter only one couse per line for (9), (b), ond (c).) PART I. DEATH WAS CAUSED BY:	ricile Fail	INTERVAL BETWEEN ONSET AND DEATH
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	Jires Jires Jired Jirial- rial,		Conditions, if ony, which gove (b) Crehro Pa	scula accessed	1 Months
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	AN: The law requires that a cattending physician icate has been signed by far use as the burial-traited the late of the late o	ATION	PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN	IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO
		CERTIFICATION	20₀. ACCIDENT WAS UNDERLYING ☐ DEATH OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter noture of injury in Port I or Port	l of item 1B.)
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	TTO tain tain tain tain tain tain tain tain		220. SIGNATURE		22b. DATE SIGNED,
	OR ATTENI be retained DIRECTOR: A je 3 should ed with the	1		A.D. PHYS. DIRECTOR D	STAFF 12/11/67
	4 may NERAL I for, page all be fill		22c. PHYSICIANS MAME (Type) MAX C FRANK A	22d. ADDRESS 425 SE Mis	this Hay blen Benja
	TO HOSPITAL OR ATTENDING Page 4 may be retained by the FUNERAL DIRECTOR: After director, page 3 should be filed with the State	230	BURIAL, CREMATION, 23b. DATE THEREOF 23C NAME OF CEMETERY OR	R CREMATORY 220 LOCA	ATION (City or Town) (County) (State)
	2 P P VR A15 (4)	24	FUNERAL PIRECTOR ADDRESS	2So. RECD BY REGISTRAL DEC 13	25b. REGISTRAR'S SIGNATURE
	25M 1/67	1	Illeam seesettelling.	ACL DATE DEC 13	1001 francis Judge

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16353 CERTIFICATE OF DEATH **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 haurs after death. 1. PLACE OF DEATH 2. USBAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND CITY OR YOWN (If outside corporate limits, c. CITY OR-TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. fill d in by write RURAL and give negrest town) e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES NO NAME OF Middle 4. DATE Month Yeor Doy DECEASED OF DEATH event, IF LINDER 1 YEAR 6. COLOR OR RACE 9. AGE (In veors SEX 7 MARRIED NEVER MARRIED B. DATE OF BIRTH lost birthdov) Months Dovs Hours WIDOWED DIVORCED 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT physician a ducing most of working life, even if retiped YUMM INDUSTRY 13. FATHER'S NAM 14. MOTHER'S MAIDEN, NAME ar remaval, attending p IS. WAS DEGLASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, of unknown) (If yes give wor or dates of service) crematian, IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH Arteriosclerotic Hear t Disease IMMEDIATE CAUSE (o) 4 may be retained by the haspital ar attending physician. DUE TO Generalized arteriosclerosis Conditions, if ony, which gove 1956 rise to immediate couse (o), DUE TO stating the underlying cause last 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NOXX Previous Coronary Thrombosis 1956 certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING [CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Dov. Yeor Hour o.m. foctory, street, office bldg., etc.) While Not While ot work ot work 21. I certify that (I) (this hospital) attended the deceased from July 19 66 to Dec. 19 67, that (1) (we) last sow the deceosed alive on Nov. \ 19 67, and that death accurred at 5A M, from causes and on the date stated above DIRECTOR: 22o. SIGNATURE ATTENDING X XX MED. DIRECTOR Mrn-M.D. director, page 3 shauld be filed v 22d. ADDRESS Page 4 may b 22c. PHYSICIAN'S TO FUNERAL NAME (Type) Severna Park, Maryland Francis I. Codd M.D. 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOJ (County) **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16354 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS Defense. NO X in Item 18. Give Pages YES e Star 24 hours after death Office along with NAME OF Middle 4. DATE Month Year Doy DECEASED 12 1967 (Type or print) DEATH NEVER MARRIED IF UNDER 24 HRS SEX 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED lost birthdoy) Months Dovs Hours WIDOWED DIVORCED 72 hours after deoth 23 pages lond2 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 12. CETIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY: SURVEYOR 13. FATHER'S NAME This certificate should be executed within in pencil 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. word 'pending'' i the Chief Medicol (Yes, no, or unknown) (If yes give wor or dates of service) event within INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per ling-for (o), buriol-tronsit PART I. DEATH WAS CAUSED BY-ONSET AND DEATH IMMEDIATE CAUSE (o) wedler writing the word DUE TO in any Conditions, if ony, which gove 9 rise to immediate couse (o). DUE TO stoting the underlying couse forworded ond removol, WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) PERFORMED? certificate, NO YES pe 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 3 should 10 cremotion, 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Yeor INJURY OCCURRED (City or town) (Stote) foctory street, office bldg., etc.) Not While FUNERAL DIRECTOR: Page 11/ of work pleose execute 21. I certify that I took charge, of the remains described above, held an Autopsy Inspection ... Inquiry and in my apinian Suicide -Hamicide death resulted fram Undetermined manner funerol director. Accident may be retoined CHIEF MEDICAL EXAMINER prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY necessary, DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health Address (Street, city, town, or county) NAME (Type) CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b. DATE 0 REGISTRAR'S SIGNATUR 2So. REC'D BY REGISTRAR VR A15ME



MARYLAND STATE DEPARTMENT OF HEALTH 16355 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 17885 CERTIFICATE OF DEATH by the funeral Pages 1/2 p DECEASED-NAME First Middle Lost 2g. DATE OF DEATH (Type or print) Ment /29 Day Albert Jacobs 3. SEX 4. RACE ouriai-transit permit. Then please remave carban papers. Pages I/ burial, cremation, ar removal, and in any event, within 72 haurs afte/ S. DATE OF BURING 6. AGE (In years IF UNDER 1 YEAR Male White lost birthday) 7a. BIRTHPLACE (State or foreign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH B. MARRIED NEVER MARRIED attending physician and campletely filled in permit. Then please remaye carban papers. Pennsylvania USA Anne Arundel WIDOWED DIVORCED [10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12o. USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR e State Hosp during most of working life, even if retired.) give street oddress) vil INDUSTRY Crownsville 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET AND NUMBER admission) STATE Maryland 13b. COUNTY YES 🔽 NO T 208 E. Baltimore Street Baltimore 14. FATHER'S NAME First Middle Lost IS. MOTHER'S MAIDEN NAME First Middle K Jacobs Charles Margaret ? 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT Yes po or unknown) (If yes give war or dates of service) 188-20-2558 Hospital Records, Crownsville, Maryland CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Caption Vasc BETWEEN ONSET AND DEATH Cardio vascular accident(right hemiplegia) IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF signed by the burial-transit p Conditions, if any, which gave) arteriosclerotic hypertension with vascular disease. rise ta immediate cause (a), DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) **D FUNERAL DIRECTOR:** After this certificate has been director, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 20o. AUTOPSY? CAUSES OF DEATH? NO I YES 🗍 21o. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 1B.) OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Month Day Year (If either, notify medical examiner) 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,) 21f. LOCATION Street or R.F.D. No. City or Town County While Nat while at work 22a. I certify that (I) (this haspital) attended the deceased from 101, 19, 67 to 12/29, 19, 67, that (I) (we) last saw the deceased alive an 12/29, 19, 67 and that in (my) (our) opinion death occurred on the date and hour and from the

couses stated obove, (I) (we) (did) (did not) view the bady after death. 226. SIGNATURE

Hildagarde Reissman, M.D. 23b. DATE

23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md.

DEGREE

ATTENDING

22e_ADDRESS

PHYS

23d. LOCATION (City or Town)

PHYS.

Crownsville State Hospital, Marvland

(County) (State)

State

2b. HOUR

IF LINDER 24 HRS.

HOURS

1:30w

30M REV. 1/69

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requires that the death certificate be executed within 24 haurs after death

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician.

23o. BURIAL CREMATION. REMOVAL (Specify) 24. FUNERAL DIRECTOR

22d. PHYSICAN'S

NAME (Type)

ADDRESS

DIRECTOR

250. RECU BY REGISTRAR 1968. REGISTRAP'S SIGNATURE

22c. DATE SIGNED

12/29/67

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	plet car car	S. S	Type or print)	6. COLOR OR RACE	sie 7. MARRIED		S. NEVER MARRIED	1 8	Janson DATE OF BIRTH	DEA	9 AGF (In years	IF UNDER 1 YEA		19 6 7 UNDER 24 HRS.
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	requires that the death certificate be executed within 24 hours after death g physician. n signed by the attending physicion and completely filled in by the funeral e buriol-transit permit. Then please remove carbon papers Pages I and 2 o buriol, cremotion, or removal, and in any event, within 2 haurs after death		18. CAUSE OF DE	EATH (Enter only one cou TH WAS CAUSED BY:	se per line for	(o), (b)	, and (c).)	7/	1. 1	1/	0		INTERVA	AL BETWEEN AND DEATH
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	AN: al o icate for Heo	TEC	20o. ACCIDENT WAS	UNDERLYING	20b. DE	SCRIBE	HOW INJURY OCCURR	RED. (Er	nter nature of injur	y in Port I or	Port II of item 18.)			
	SIC spit ertif eed t. of	CER.	(IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER)										
	PHY e ho nis c tach tach	MEDICAL	20c. TIME OF INJU	JRY Month, Doy, Year n.					OF INJURY (Home,		f. (City or town)	(County)		(Stote)
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	ret ref 3 st wit		220. SIGNAFURE	1100	XIII	la	mm	M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	7 /2/	UINOU	/12
	od / pe		22c. PHYSICIAN'S	awn je	Tou	- 00	7770	M.U.	22d. ADDRESS	DIRECTOR	rats. L		//	
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	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Poge 4 may be retained by the hospital or ottending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the buriol-transhould be filed with the State Dept. of Health prior to buriol, cree	230	. BURIAL, CREMATIC	DN, 23b. DATE THE	REOF	23c.	NAME OF CEMETERY	OR CR	REMATORY	. 23d.	LOCATION (City or T	lown) (Cou	ınty)	(Stote)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16357 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STAT 16348 PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission b. COUNTY Anne Arundel o. CDUNTY o. STATE Maryland deloy is and 3 to Page Anna Arundel MARYLAND c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give neorest town) P.M3 Mins. Rural - IOTHIAN Departr d. NAME DF HDSPITAL DR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENC DN A FARM? Office olong with farm in Item 18. Give Poges 1, YES NO XX Anne Arundel General Hospital D.O.A Route 1 - Box 173 24 hours ofter deoth. NAME OF First Lost Month Year DECEASED (Type or print) JAMES 111 Dec. 10 67 JOHN SON WEBSTER 19 9. AGE (In years IF UNDER 24 HRS S. SEX 6. COLOR DR RACE DATE OF BIRTH IF UNDER 1 YEAR NEVER MARRIED lost birthdoy) Aug. 22-67 Male Negro 11. BIRTHPLACE (Stote or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND DF BUSINESS DR 12. CITIZEN DF WHAT COUNTRY? S.A. during most of working life even if satired INDUSTRY SEX NEW XX Calvert Co. Maryland in pencil i 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within Gladys Jenkins Johnson LOTHIGANS, MARYLAND 17 INFORMANT 16. SOCIAL SECURITY ND word "pending" i (Yes, no, or unknown) (If yes give wor or dotes of service James W. Jehnson Jr. Rt.1-Box173 event within INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o) (b), and (c).) burial-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) This certificate should writing the word Heash DUE TO any Conditions, if ony, which gove (b) 9 rise to immediate couse (o), \subseteq DUE TD stating the underlying couse 0 and OS 19. WAS AUTDPS' PERFORMED? removol. PART 11. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) ND C pe 20g EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 3 should PRIMARY I or CONTRIBUTING I 10 MEDICAL EXAMINER: CAUSE DF DEATH crematian, MEDICAL (Stote) 20d INTURY DCCLIRRED 20e. PLACE DF INJURY (Home, farm (City or town) (County) 20c. TIME DF INJURY Month, Doy, Year Not While Hour o.m. foctory, street, office bldg., etc.) may be retained for your FUNERAL DIRECTOR: Page of work 2]. I certify that I took charge of the remoins described obove, held on Autopsy Inspection ond in my opinion Undetermined monner deoth resulted from Natural couses Accident [Suicide | Homicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED wills & ASSISTANT MEDICAL EXAMINER prior SIGNATUR necessary, DEPUTY MEDICAL EXAMINER FUNE Heelth Address (Street, city, town, or county) NAME (Type) E.G. LINHARDT 23b. DATE THERED F 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) 23o. BURIAL, CREMATION A.A.Co. Maryland MOSES Burial (Specify) Dec. 12-67 ADDRESS 25o. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15ME (5 Melanles C.E. Hicks 111 Annapolis, Marylahd

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16359 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY ANNE ARUNDEL MARYLAND b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 CHESAPEAKE DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ROUTE #3, BOX 189 KIMBROUGH ARMY HOSPITAL NO Z NAME OF Middle 4. DATE First Year ottending physician and completely sermit. Then please remove corbon DECEASED OF DEATH DECEMBER LEON JONES (Type or print) B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Hours NEGRO MALE OCT 24, 1946 WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT USA COUNTRY? during most of working life, even if retired)
Soldier INDUSTRY Ahoskie, N.C. U.S. Army 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova Annie E. Ruffin Jessie Jones, Jr. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) Official military records 23Mar66-9Dec67 230-66-6533 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL BETWEEN burial-transit burial, cremoti ONSET AND DEATH PART 1. DEATH WAS CAUSED BY. MENINGOCOCCEMIA IMMEDIATE CAUSE (o) þ DUE TO signed Conditions, if ony, which gove rise to immediate couse (o). DUE TO stating the underlying cause 19. WAS AUTOPS'
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YES NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) None ATTENDING PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 2Do. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. Not While foctory, street, office bldg., etc.) ot work TO FUNERAL DIRECTOR: After IX 9 DEC 21. I certify that () xitax residue of conced the deceased XXXX WAS DOA XX 167, that I CONTON be retained ond that death accurred at 5:35 M, fram causes and on the date stated above DISTRIBUTION DE 2019 ON THE CHARLES 22b. DATE SIGNED ATTENDING MED. DIRECTOR STAFF PHYS. 9 DEC 67 22d. ADDRESS Poge 4 may KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD NAME (Type) FREDERICK SHUSTER, CPT, MC 23b. DATE THEREOF 12/14/67 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (County) (Stote) Norfolk, Virginia Bismayal & pecify) Rosewell Cemetery ADDRESS Ellicot City REC'D BY REGISTRAR 24. FUNERAL DIRECTOR HOWARD COUNTY 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 DATE UE G Funeral Home Harry Witzke DO Maryland

Item 18 Film 396 1-8-68 MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16360 16351 CERTIFICATE OF DEATH after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY a STATE MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits. c. LENGTH OF STAY IN 16 write RURAL and give nearest tawn) ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours 30 me e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS BCH. YFS NO L NAME OF Middle DATE Manth carban Last Doy Year DECEASED 31 DEATH 19 6 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Manths last birthday) Dovs Haurs WIDOWED DIVORCED and in any 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE/County & State, ar foreign cauntry) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY, COUNTRY? hussing 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes no, ar unknown) (If yes give war or dates of service) CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEE ONSET AND DEATH burial-transit Coronery IMMEDIATE CAUSE (a) by the haspital ar attending physician. DUE TO Canditians, if any, which gave rise ta immediate cause (a). DUF TO stating the underlying cause priar ta as the lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 7 d 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED (County) Hour o.m. factory, street, affice blda., etc.) Nat While at wark at wark , 1965 ta Dec. 3/ , 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram Zel-O HOSPITAL OR ATTEND Page 4 may be retained 1967, and that death accurred at 1/30 M, from causes ond on the date stated obove. saw the deceased alive an Dec 36 22b. DATE SIGNED 22a. SIGNATURE ATTENDING directar, page s shauld be filed v M.D. DIRECTOR PHYS 22d. ADDRESS 21214 22c. PHYSICIAN'S FUNERAL NAME (Type) Harford Kd Balle. md 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (State) 23a. BURIAL, CREMATION REMOVAL (Sperify) 9 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16361 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 16353 HEALTH DEPTE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY DA CO delay is and 3 to A3. Page MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 e RURAL ond give neorest town) PASE deNA -1ASHdewA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS e IS RESIDENCE ON A FARM? RL11-Bay 61 PO in Item 18. Give Pages NO V This certificate should be executed within 24 hours after deoth. Sto along with NAME OF Middle Los DATE First Month Year DECEASED 1967 Leroy (Type or print) DEATH IF UNDER 1 YEAR SEX NEVER MARRIED 8. DATE OF BIRTH 05 9. AGE (In years IF UNDER 24 HRS 7. MARRIED lost birthdoy) Months 40XX WIDOWED DIVORCED Office ond 2 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRYS during most of working life, even if retired) INDUSTRY Sign Artist
13. FATHER'S NAME Self Employed Pennsylvania

14. MOTHER'S MAIDEN NAME the Chief Medical Examiner's Reath Mays George W. Kelley 21122 fs. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) event within Mrs. Agnes C. Kelley Rt.11 Box 61 Pasadena NHERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) SFT AND DEATH buriol-tronsit PART 1. DEATH WAS CAUSED BY: writing the word DUF TO dny Conditions, if ony, which gove rise to immediate couse (o), DUF TO stoting the underlying couse 19. WAS AUTOPSY PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) removol, PERFORMED? CERTIFICATION certificote, NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item IB.) PRIMARY Or CONTRIBUTING EXAMINER: CAUSE OF DEATH. cremation, 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) foctory, street, office bldg., etc.) Hour o.m. . Not While DIRECTOR: Page of work 21. I certify that I took shorpe of the remains described above, held on Autopsy ... Inspection . Inquiry ond in my opinion 5 deoth resulted fra -Natural causes Accident Suicide . Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER L SIGNATURE Health prior FUNERAL DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL, CREMATION, 0 REMOVAL (Specify) Glen Haven Memorial Park Glen Burnie Anne Arundel Co. Milaries VR A15ME Tunual Home 237 Patapsco Ave. 21225 DATE DEC 11 1967

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE. MARYLAND 21201 16362 CERTIFICATE OF DEATH 16354 PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) . PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town)

Baltimere Suburban c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 yrs. Baltimere Suburban p e. IS RESIDENCE .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS papers ON A FARMS filled 906 Victory Ave. 906 Victory Ave. 00 NO K and in any event, within NAME OF DATE Lost Year remave carban campletely DECEASED Ella E. Lanham 19 67 Dec. 10 DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH **NEVER MARRIED** 7 lost birthdoy) Months Hours White Female June 26, 1888 WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife COUNTRY? attending physician overmit. Then please **INDUSTRY** None Baltimore, Md.

14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME burial, crematian, ar removal, William J. Ford Ella Grant IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no or unknown) (If yes give wor or dotes of service) Mr. John Sedlmayer 4713 Meist Drive (21206 None 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Hypertensive cardio-vascular diesse IMMEDIATE CAUSE (o) _ **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. DHE TO Generalized arterio-sclerotic heart Conditions, if ony, which gove rise to immediate couse (a), disease DUE TO stoting the underlying couse this certificate has been director, page 3 shauld be detached far use as the should be filed with the State Dept. of Health prior ta Senile dementia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20d. INJURY OCCURRED (City or town) (County) 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Yeor foctory, street, office bldg., etc.) Hour o.m. Not While ot work FUNERAL DIRECTOR: After 1919 66, to Dec 10, 1967, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. 18 67, and that death accurred at 5 4 M, fram causes and an the date stated above saw the deceased alive an. 22b. DATE SIGNED 220 SIGNATURE ATTENDING PHYS. STAFF PHYS. Dec. 11, 1967 DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Rubin 201 E. Patansce Ave. Samuel 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Ritchie Hwy. A. A. Co., Dec. 13, 1967 Cedar Hill Cemetery 2 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR 1967 George J. Gonce 4001 Ritchie Hwyl (21225)

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16363 16355 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY g. STATE b COUNTY Anne Arundel OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) D. O.A. Severna Park Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Med North Arundel Hospital 594 Manor Road NO X Wiffain NAME OF Middle 4. DATE First Last Month Day Year remove corbo DECEASED 12 (Type or print) Herbert 31 1967 Lappe DEATH 9. AGE (In years S SEX 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED last birthdoy) Months Days ond in ony White WIDOWED DIVORCED 11-8-98 Male puo 10g. USUAL OCCUPATION (Give-kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN, OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY physicion 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, nogor unknown) (If yes give war ar dates of service) INFORMAN' Address 16. SOCIAL SECURITY NO permit. cremation, CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital or attending physicion. DUE TO Canditions, if any, which gave rise to immediate cause (a) DUE TO stating the underlying couse State Dept. of Health prior to last. 0.5 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? NO X certificote 0 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) Hour o.m. Not While foctory, street, affice bldg., etc.) at wark Lee 51, 1960, that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from ta 11 19 67, and that death occurred at 412 M, from couses and an the date stated above FUNERAL DIRECTOR: saw the deceased alive on 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** director, poge 3 M.D. PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY BURIAL CREMATION 23b DATE THEREOF 230 LOCATION (City or Town) (County) (State REMOVAL (Specify) 259 RECD BY REGISTRAR VR A15 (4) 25M 1/67 Severna Park, Md. Barranco DATE

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16365 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel Anne Arundel ages 1 MARYLAND Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) .⊆ d. STREET ADDRESS e. IS RESIDENCE ON A FARM? completely filled 123 Cathedral St. Anne Arundel General Hospital YES NO X corbon 3. NAME OF First Middle Lost 4. DATE Year Dov DECEASED LEVY 19 67 15 Joseph (none) December (Type or print) DEATH 6. COLOR OR RACE 7. MARRIED 9. AGE (In years lost birthdoy) IF UNDER 1 YEAR S. SEX B. DATE OF BIRTH IF UNDER 24 HRS. NEVER MARRIED Doys Hours White Male WIDOWED | DIVORCED Oct. 5. 1886 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT the attending physicion of sit permit. Then please INDUSTRY COUNTRY? Baltimore City Maryland proprietor retail dress 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, cremotion, or removal, David Levy unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMANT 16. SOCIAL SECURITY NO. Address Rose Goldberg Levy - same as #2 above 215-16-5735 no 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) physicion. DUF TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse FUNERAL DIRECTOR: After this certificate has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? detached for use e Dept. of Health YES T NO OR ATTENDING PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Not While factory, street, office bldg., etc.) of work ot work , to Dec. 15, 1967, that (I) (DOX) last 21. I certify that (I) (this position) attended the deceased from. . 19 be retoined M, from couses and on the date stated above 220. SIGNATURE 22b. DATE SIGNED director, page 3 M.D. DIRECTOR PHYS. 42c. PHYSICIANS 22d. ADDRESS NAME (Type) Stephen B. Hiltabidle, M.D. 121 Cathedral St., Annapolis, Md. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (State) REMOVAL (Specify) Kneseth Israel Cemetery Annaj 0 12/17/67 Annapolis Md Burial 24 FUNERAL QUECTOR E. Hopping Annapolis, 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) Melinelas Judas DATE DEC

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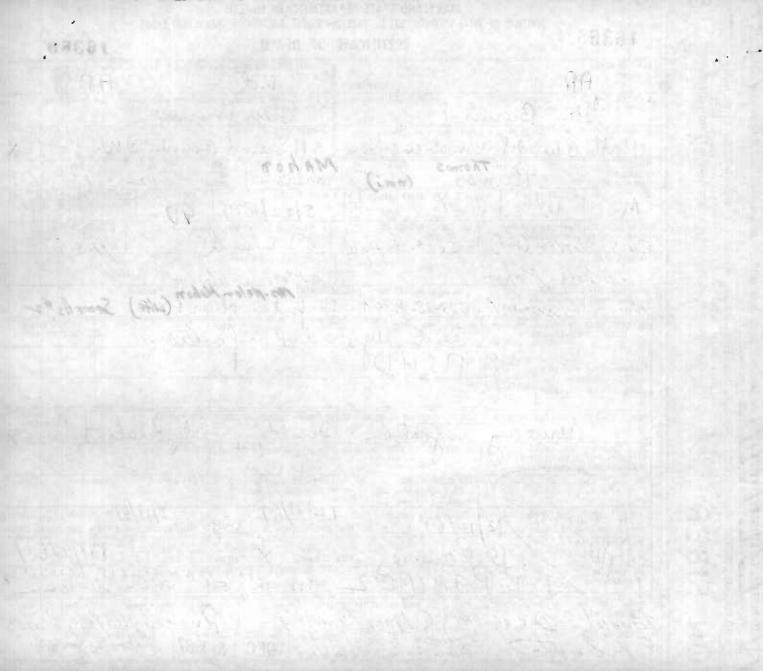
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16367 CERTIFICATE OF DEATH 16359 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE 6 COLINTY Anne Arundel MARYLAND Maryland Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn) requires that the death certificate be executed within 24 hours Annapolis Annamolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENC ON A FARM? lled Anne Arundel General Hospital 23 Acorn Drive NO V 3. NAME OF Middle 4. DATE Month Dov Year DECEASED YE TE DUELES 196 (Type or print) 100 DEATH SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS NEVER MARRIED lost birthdoy) Months Doys Hours WIDOWED DIVORCED Sept. 1918 female caus. gud 11. BIRTHPLACE (County & Stote, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? wholesale auto parts s Maryland

14. MOTHER'S MAIDEN NAME secretary USA 13. FATHER'S NAME ar removal, attending phy Joseph Stubbins Marian Summers 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service 579-18-5735 | Walter E. Loveless - same as #2 cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL BETWEEN signed by the burial-transit PART I. DEATH WAS CAUSED BY RUZULIA IMMEDIATE CAUSE (o) DUE TO BSTRUCTION, 5 MALL BOWEL Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse the has been TENSIVE SOUTHOUS CELL CARCINOUN OF 6 lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAP DIPLASE CONDITION ON THE PART I 00 PART 10 ME TAS IS DERFORMED? 10 FUNERAL DIRECTOR: After this certificate for 200. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work 21. I certify that (1) (this hospital) attended the deceased fram MARCH, 1967, toll 1863 . 1967, that (1) (-) last be retained saw the deceased alive an Dr. 2 2 19(27, and that death accurred at 0 M, fram causes and an the date stated above. 920. SIGNATURE 22b. DATESIGNED ATTENDING PHYS. STAFF PHYS. tar, page 3 M.D. DIRECTOR 22c. PHYSICIAN'S NAME (Type) OBER should 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY direct 23o. BURIAL, CREMATION, 23d. LOCATION (City or Town) (Stote) (County) Burial (Specify) Dec. 27.1967 Hillcrest Memorial 250. REC'D BY REGISTRAR'S SIGNATURE Hopping VR A15 (4) 25M 1/67 harles DATEC 1967 FUNERAL HOME - Annamolis

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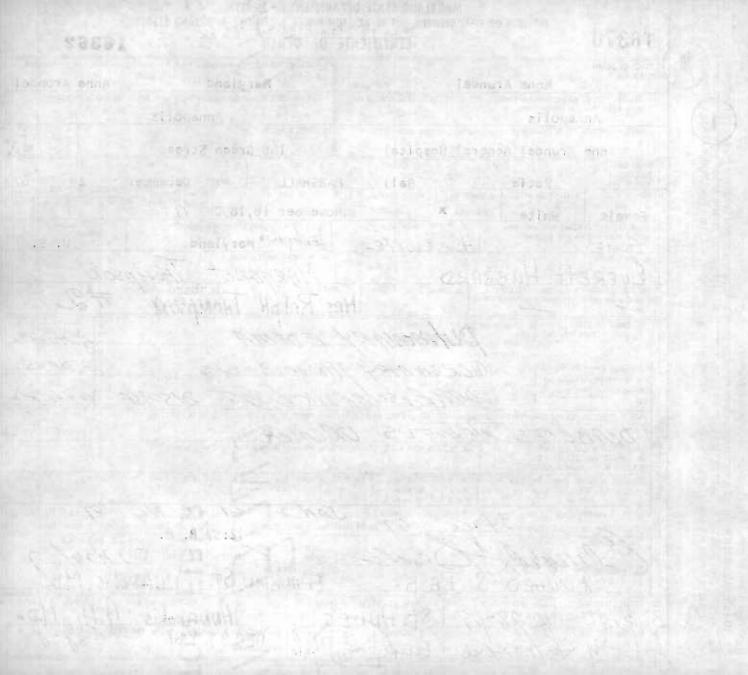
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16368 CERTIFICATE OF DEATH 16369 deont? requires that the death certificate be executed within 24 hours after death. funeral . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY hours after MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR JOWN (If autside exparate limits, write RURAL and give nearest tawn) write RURAL and give nearest 46 m d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ban paper within 72 NO X NAME OF Pan Middle DATE First Thomas Day Year DECEASED OF DEATH (nmi signed by the attending physician ond complet burial-transit permit. Then please remove cor buriol, cremation, or removol, and in ony event, (Type or print) 196 SEX 9. AGE (In years 6. COLOR OR RACE B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED birthday) Manths Days Hours WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work dane 1Db. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or/foreign country) during mast af warking life, even if retired? INDUSTRY COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) ((If yes give wor ar dates of service) 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse the prior to has been OR ATTENDING PHYSICIAN: The law PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Heolth Duy NO O FUNERAL DIRECTOR: After this certificate YES by the hospitol or For 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) Haur o.m. factory, street, office bldg., etc.) Nat While at wark at wark I certify that (1) (this haspital) attended the deceased from , that (I) (we) lost Page 4 may be retained sow the deceased alive on and that death accurred at M, fram causes and an the date stated above. 22a SIGNATURE DATE SIGNED M.D. DIRECTOR RHY SIRIAN'S 22d. ADDRESS 3 5 2 NWAPOL NAME (Type) BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 24. EUNFRAL DIRECTOR 2Sa. REC'D BY REGISTRAR DADEC 25M 1/67



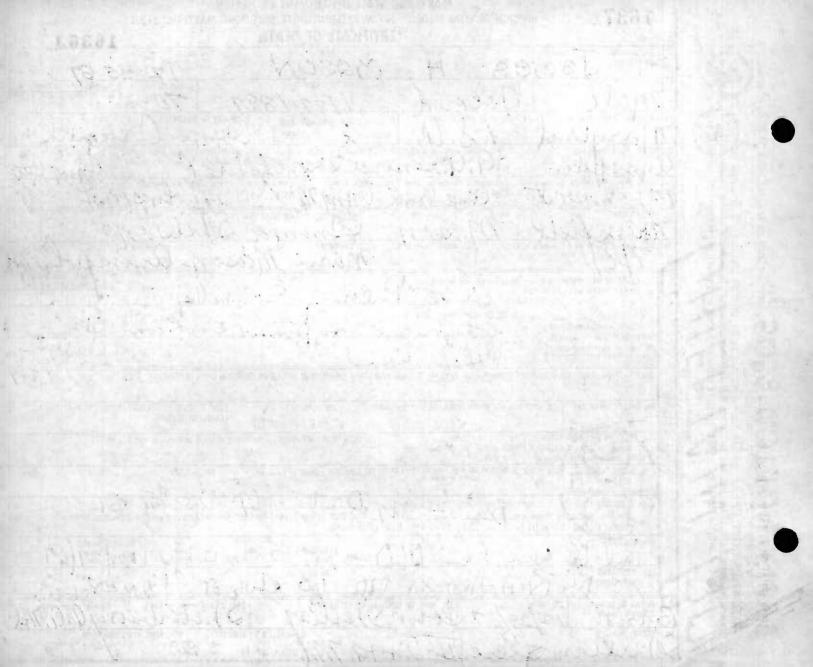
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16361 16369 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b COUNTY Anne Arundel MARYLAND Anne Arundel Maryland Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street addless) Glen Burnie OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hour d. STREET ADDRESS e. IS RESIDENCE ON A FARM? papers. event, within 72. NO T YES North Arundel Hospital RED. Box Middle Doy 3. NAME OF First 4 DATE Month Year corbon DECEASED 19 67 Richard Narshall December 17 Don (Type or print) IF UNDER 24 HRS IF UNDER 1 YEAR S SEX B DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED X **NEVER MARRIED** remove hirthdov) Months Hours 7-30-10 cremotion, or removol, and in any WIDOWED DIVORCED Male 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Truck Driver
13. FATHER'S NAME eryland TransferrNorth Carolina Unknown Cleve Marshall 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. permit. (Yes, no, ocunknown) (If yes give war or dates of service) 237-24-8682 Mrs. Viola C. Marshall. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ONSET AND DEATH buriol-tronsit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospitol or ottending physicion. DUE TO Conditions, if ony, which gove rise to immediate cause (o). DUE TO stating the underlying couse **DIRECTOR:** After this certificate has been the 19. WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) of Heolth NO YES T 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) Hour o.m. Not While director, page 3 should be de should be filed with the State ot work 21. I certify that (I) (this hospital) ottended the deceased from 1967, and that death of . 1967 . to 1967, that (1) (we) las 1967, and that deoth occurred at 11:40AM, fram causes and an the date stated above saw the deceased alive an 220 SIGNAPURE 22b. DATE SIGNED ATTENDING DIRECTOR M.D. PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S FUNERAL NAME (Type) 510 Marley Station Rd. Edmond I. Moushabek G.B 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b, DATE THEREOF (County) (Stote) 23o. BURIAL CREMATION, REMOVAL (Specify) Glen Burnie Glen Haven Menorial 0 2Sb. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Crespelly VR A15 (4) 20 M 1/66 Kirkley Funeral Homen Glen Burnie, Mi.

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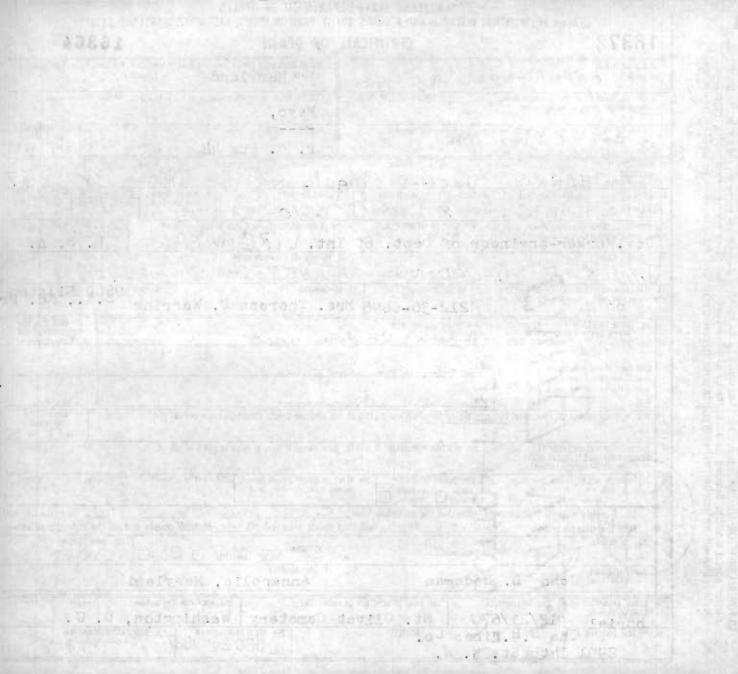
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16370 OF DEATH CERTIFICATE 16362 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH o. COUNTY a. STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND offer b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) requires that the death certificate be executed within 24 hours Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS 168 Green Street NO X Anne Arundel General Hospital YES 3. NAME OF Lost 4. DATE Month Doy Year DECEASED December Be 11 (Type or print) Katie MARSHAL DEATH AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH lost birthdoy) Months Dovs Hours DIVORCED November 18,1890 and in ony WIDOWED X White Female KIND OF BUSINESS OR BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY COUNTRY? Maryland U. S. HOME 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremotion, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (o), (o), ond (c).)
PART I. DEATH WAS CAUSED BY: by the hospital or attending physicion. DUF TO Conditions, if ony, which gove rise to immediate couse (a). DUF TO stoting the underlying couse **ATTENDING PHYSICIAN: The law** last. ds WAS AUTOPS' PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 200. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d INIURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) TO FUNERAL DIRECTOR: After this Hour 'o.m. foctory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased fram be retained director, page 3 should shauld be filed with the from causes and on the date stated above. , and that death accurred at saw the deceased alive an 22b. DATE SIGNED 220 ALGHATUR DIRECTOR PHYS. 22d. ADDRESS 230. BURIAL, CREMATION 23b. DATE THEREOF FUNERAL DIRECTOR



	MARYLAND STATE DEPARTMENT OF HEALTH
	16371 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	CERTIFICATE OF DEATH 16363
	DECEASED-NAME First Middle Lost , 20. DATE OF DEATH 2b. HOUR
(1	Type or print) James H Mason Month Doys Engl
3. 51	S. DATE OF BIRTH 6. AGE (In years if under 14 AR If under 24 ARS) 4. RACE A. MONTHS DAYS HOURS MIN
	Male Colored 1/27/1897 last titlday) yrs. MONTHS DAYS HOURS MIN
70.	BIRTHPIACE (State or foreign 7b. CITIZEN OF WHAT COUNTRY?) 8. MARRIED NEVER MARRIED 9 COUNTY OF DEATH
17	original d. S. I. WIDOWED DIVORCED Ungse Christian N
19.4	CITY FOR TOWN OF DEATH It have Grides I are institution (if not in hospital during most at working life even if retired.) It have Grides I are institution (if not in hospital during most at working life even if retired.) INDUSTRY
1	manual of the care of the care
13o.	. USUAL RESIDENCE (Where deceased lived, if institution: Residence before 13c. CITY OR TOWN 130 INSIDE BY LIMITS? 13e. STREET AND NUMBER prishing STATE AND TOWN 130. COUNTY 1.00 INSIDE BY LIMITS?
L	4 portification of the state of
(A)	FAMILER'S MAIDEN NAME First Middle Lost 15 MOTHER'S MAIDEN NAME First Middle Lost
140	WAS DECLASED EVEN IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. LIZ. INFORMANT Address
	Yes, ng/or unknown / (If yes give war or dates of service) > 100. 30 CIAL SECONTITIO. Major Manuel Major Maj
-	APPROXIMATE INTERVAL
и	IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (d) PART I. DEATH WAS CAUSED BY:
	IMMEDIATE CAUSE (a) CECTED ALLOWA THE STATE OF THE STATE
	Canditians, if any, which gave) DUE TO, OR AS A CONSEQUENCE OF
	rise to immediate cause (a), Stating the underlying rause DUE TO, OR AS A CONSEQUENCE OF).
	stating the underlying cause lost. (c) Chila. Case and
	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(0)
N	
CATIO	19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
RIE	YES NO CAUSES OF DEATH?
	Eld field fi
EDIC	(If either, natify medical examiner) P.M. 19
2	21d. INJURY OCCURRED While Not while 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street ar R.F.D. No. City ar Tawn Caunty State
	di wark ali work
1.	sow the deceased glive an Dec. 231 1961, and that in (my) (aur) apinfon death accurred on the date and hour and from the
И	causes stated abave, (1) (we) (did) (did nat) view the bady after death.
	22b. 90NATURE 22c. DATE SIGNED 22c. DATE SIGNED 22c. DATE SIGNED
	DEGREE PHYS. DIRECTOR PHYS.
	22d. PHYSICIAN'S RL. RIGHT RODGEN ATTO 22e. ADDRESS
100	AND COMMENT OF CHATTON OF COMMENT OF CHATTON OF COMMENT OF CHATTON OF COMMENT OF CHATTON
230	BURIAL CREMATION, 23b. DATE, 28c. NAME OF CEMETERY OR CREMATORY 28 LOCATION (Gry or Town) (County) (State)
230	BURIAL, CREMATION, 23b. DATE, 22c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specific) PUNERAL DIRECTOR ADDRESS
	70. 130. 130. 14.



MARYLAND STATE DEPARTMENT OF HEALTH



16373 **TO FUNERAL DIRECTOR**: After this certificate hos been signed by the attending physician ond completely filled in by director, page 3 should be detoched for use os the buriol-transit permit. Then please remove corbon papers. Poshould be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in ony event, within 72 hogh

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16365

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institut	tion: Residence before admission)
o. COUNTYANNE ARUNDEL	MARYLANI	O. STATE MARYTAND b. COU	NIYANNE ARUNDEL
b. CITY OR TOWN (If outside corporate limits,		c. CITY OR TOWN (If outside corporate limits, write RU GLEN BURNIE	RAL ond give neorest town)
d. NAME OF HOSPITAL OR INSTITUTION (IF NOT KIMBROUGH ARMY HOSP)		d. STREET ADDRESS 426 ARBOR DRIVE	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED (Type or print) JOHN THOM		Lost 4. DATE Mon OF DECEMBE	
5. SEX MALE 6. COLOR OR RACE CAU	7. MARRIED NEVER MARRIED DIVORCED	8. DATE OF BIRTH 9/15/1929 9. AGE (In years lost birthdoy) 38 yrs.	Months Doys Hours Min.
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR SOLDIER	11. BIRTHPLACE (County & Stote, or foreign country) WEBSTER, NY.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME WILLIAM HENRY MC COY		14. MOTHER'S MAIDEN NAME	SENERAL CONTRACTOR
IS WAS DECEASED EVER IN ILS ARMED EDROES?	16. SOCIAL SECURITY NO.	JANET E. BROWN 17. INFORMANT Addr.	
YES, or unknown) (Ityes give yor or do sof	service) 081-32-8110	BEVERLY MC COY(W) Same as #	
1B. CAUSE OF DEATH (Enter only one cous PART I. DEATH WAS CAUSED BY:		EDEMA, CONGESTIVE HEART	INTERVAL BETWEEN ONSET AND DEATH
4341 IMMEDIATE CAUSE (TO A TET TYPE	EDEMA, CONGESTIVE HEART	
Conditions, if ony, which gove	b)		Approx lyr
rise to immediate couse (a), stating the underlying couse last.	(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CO	NTRIBUTING TO DEATH BUT NOT RELATED	TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)	19. WAS AUTOPSY PERFORMED? YES X NO
200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCUR	RED. (Enter noture of injury in Port I or Port II of item IB.)	
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19	20d. INJURY OCCURRED While Not While of work	PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)	(County) (Stote)
saw the deceased alive an 1	ital) attended the deceased fran L Dec 67 19 , and	that death accurred at 3:30 M, fram causes	and an the date stated above
Synn W.	Holder GXM		
22c. PHYSICIANS NAME (Lyve) LYNN W. HO	OLDER, CPT, MO	KIMBROUGH ARMY GOSPITA	L, FT GEO G MEADE
230. BURIAL, CREMATION, REMOVAL (Specify) Burial 12/14/		National Arlington	wn) (County) (State)
24. FUNERAL DIRECTOR			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after death Poge 4 may be retained by the hospital or ottending physicion. VR A15 (4) 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16374 CERTIFICATE OF DEATH death. requires that the deoth certificate be executed within 24 hours ofter deoth The Funeral I. PLACE OF DEATH 2. USBAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY a. STATE b. COUNTA MARYLAND b_CITY OR TOWN (If outside corparate limits, c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits write RURAL and give nearest tawn) write RURAL and give negrest town filled in NAME OF HOSPITAL INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS IS RESIDENC event, within 72 ON A FARM? NAME OF Middle corbon First DATE Year DECEASED DEATH (Type ar print) SEX DATE OF BIRTH AGE (In years IF LINDER F UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED 8. NEVER MARRIED remove birthday) Manths Haurs Days and in any WIDOWED X DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most af-warking life, even if retired) INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremotion, or removol, 16. SOCIAL SECURITY NO 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT permit. (Yes, no, or inknown) (If yes give wor or dotes of service) INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter anly one cause per line far (g), (b), and (c). buriol-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by be retoined by the hospital or ottending physicion. DUE TO buriol Canditians, if any, which gave rise ta immediate couse (o), DUF TO stating the underlying couse hos been director, page 3 should be detached far use os the should be filed with the Stote Dept. of Health prior to last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS PERFORMED? NO this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (State) 20c. TIME OF INJURY Manth, Day, Year (County) foctory, street, affice bldg., etc.) Hour o.m. While Not While 19 at wark at wark **DIRECTOR:** After 3 should be 21. I certify that (1) (this hospitel) attended the deceased fram 4-19 1967 that (1) (we) last 12/22 22 19 67, and that death occurred at 1/35AM, from causes and on the date stated above. saw the deceased olive on 220. SIGNATURE 22b. DATE-SIGNED ATTENDING PHYS. 7 M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME-OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County) Stote) REMOVAL (Speciful) 0 250. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** 2Sb. VR A15 (4) 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16375 CERTIFICATE OF DEATH 16367 death. requires that the death certificate be executed within 24 hours after death and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH COUNTY o. STATE b. COUNTY Anne Arundel Marvland Anne Arundel MARYLAND ages c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside carporate limits. c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn)
Millersville Glen Burnie d. NAME DF HDSPITAL DR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO TO Knollwood Manor Nursing Home YES 3. NAME OF 4. DATE Middle Month Day Year remave carban physician and campletely DECEASED (Type or print) Fannie DEATH McQuay Dec. AGE (In years last birthday) 8. DATE OF BIRTH IF UNDER 1 YEAR IF LINDER 24 HRS 6. CDLOR OR RACE 7. MARRIED NEVER MARRIED Manths 6/23/1879 WIDOWED T DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or fareign country) during most of working life, even if retired) INDUSTRY USA Talbot County, Md. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME William T. Morris Anna Jester 414 Madere Ave. 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give war or dotes of service Glen Burnie. Mrs. Maysie Cayer. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED 8Y IMMEDIATE CAUSE (o) signed by DUF TO Conditions, if ony, which gave rise to immediate couse (a). DUF TO stoting the underlying couse be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? far use YES NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Not While at wark at wark , 19 66, to 12/19 21. I certify that (1) (this hospital) attended the deceased from_ . 19.67, that (I) (we) last 12/12 1967, and that death occurred at_ saw the deceased alive on AM, from causes and on the date stated above. 22b. DATE SIGNED 220. SIGNATURE STAFF PHYS. 12/19/67 DIRECTOR M.D. PHYS. director, page should be filed _22d. ADDRESS 22c PHYSICIAN'S Ray M. Smith, M. D. Hahn Professional Bldg., Severna Pk., Md. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23o. 8URIAL, CREMATION 23b. DATE THEREOF (Stote) REMOVAL (Specify) Bozman, Cemetery December 21,1967 Bozman, Maryland 2Sb. REGISTRAR'S SIGNATURE ADDRESS DATE DEC

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 16369 the deoth certificate be executed within 24 hours after deoth. funerol and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY a. COUNTY o. STATE MARYLAND ANNE ARUNDEI MARYLAND ANNE ARIINDEL Pages b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) RURAL-CT. FIN BURNTE RITRAL ODENTON filled in e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS NORTH ARUNDEL **** HOSPITAL 1245 SCOTT MANOR YES NOT corbon 3. NAME OF Middle 4. DATE First Lost Month Day Year DECEASED (Type or print) HERSCHEI DEATH DECEMBER 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED Months Dovs Haurs WIDOWED DIVORCED MALE WHITE ARCH 28.1899 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of warking life, even if retired) INDUSTRY COUNTRY? ESTIMATOR LUMBER COMPANY TLLINOIS TISA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME GaRY signed by the attending passive subviol-tronsit permit. The buriol, cremation, or remov 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT sange. (Yes, no, or unknown) (If yes give war or dotes of service) as Ha 451-03-7982 INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line fer, (a), (b), and (c).) ONSET AND DEATH PART I, DEATH WAS CAUSED BY: requires that IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse the hospital or ottending as the prior to TO FUNERAL DIRECTOR: After this certificate has been lost. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED? USe CERTIFICATION NO for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year factory, street, office blda., etc.) Hour a.m. Nat While ot wark pe be retained by 21. I certify that (I) (this haspital) attended the deceased fram // 1967, that (I) (20) last 67, and that death occurred at 214/100M, fram causes and an the date stated above saw the deceased alive an_ 22a, SIGNATURE 22b. DATE SIGNED TTENDING DIRECTOR PHYS. r, poge be filed TO HOSPITAL (Poge 4 may b 22d. ADDRESS 22c. PHYSICIAN'S Grunberg. NAME (Type) Febus M.D. 1115 Old Odenton Rd. Odenton director, shauld b 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) (County) (State) ederich Town **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) GLENWERS LDATE DEC 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16377 CERTIFICATE OF DEATH 16368 death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY Anne Arundel after MARYLAND Maryland Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL ond give necrest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 hours Edgewater d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) .5 d. STREET ADDRESS e. IS RESIDENCE filled ON A FARM? Annapolis Nursing Home Rt 2 Box 220 NO Y YES requires that the death certificate be executed within 3. NAME OF remove carbon Middle 4. DATE Lost Month 3 Doy Year DECEASED OF event, (Type or print) DEATH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy) Months Dovs Hours female ond in ony caus. WIDOWED DIVORCED Mar. 30.1879 88 puo 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) physicion on pleose COUNTRY? unknown 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, cremotion, or remaval, attending phys permit. Then p William M. Meredith Terressa A. Richey 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT unknown Mrs. Margaret Arrington - same as #2 above 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BEJWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) the hospitol or attending physician. DUE TO Conditions, if ony, which gove (b) rise to immediate couse (o). DUE TO stoting the underlying couse has been priar to (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? Heolth TO FUNERAL DIRECTOR: After this certificate OR ATTENDING PHYSICIAN: YES [NO 10 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) detached for the Dept. of I OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) Hour 'o.m. Not While foctory, street, office bldg., etc.) 19 ot work of work pe 21. I certify that (1) (this hospital) attended the deceased fram be retained with the 1967, and that death accurred at 2.45 PM. saw the deceased alive an fram causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED MED. filed M.D. DIRECTOR director, poge should be filed 22c. PHYSICIAN 22d. ADDRESS Page 4 moy NAME (Type) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) Removal Specify) 12/6/67 Cedar Hill Cemetery Suitland PrinceGeorge 24. FUNERAL DIRECTOR. ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATUR VR A15 (4) 25M 1/67 1967 FUNERAL/HOME Annapolis.

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16381 CERTIFICATE OF DEATH 16373 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. death. funeral ond . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY MARYLAND ages the CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1h OWN (If outside corporate limits, write RURAL and give nearest town) 00 in 72 b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? NO.X NAME OF Middle Lost DATE Month campletely Dov Year DECEASED 13 1967 (Type or print) DEATH event, SEX AGE (In years 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** IF UNDER 1 YEAR IF UNDER 24 HRS. Hours in any DIVORCED WIDOWED ond 100. USUAL OCCUPATION (Give kind of work dopeduing most of work in life, every imprised) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT physician ond FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal. IRAUL 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes_po, or unknown) (If yes give wor or dotes of service ELIZABETH 0 burial, crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET, AND DEATH IMMEDIATE CAUSE (o) 2 Page 4 may be retained by the hospital ar attending physician. DUE TO signed Conditions, if ony, which gove cardievarulas discous rise to immediate couse (a). DUE TO stoting the underlying couse this certificate has been ed far use as the af Health priar ta 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO A 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER filed with the State Dept. 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) Not While ot work After 21. I certify that (I) (this haspital) attended the deceased fram 1960 to 1967, that (1) (we) last 1967, and that death accurred at 7 A.M. fram causes and an the date stated above TO FUNERAL DIRECTOR: saw the deceased alive an____ 22o. SIGNATURE 22b. DATE SIGNED M.D. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) pe TORES director, should be BURIAL, CREMATION NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) (Stote) 25b. REGISTRAR'S SIGNATUR VR A15 (4 25M 1/67

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1 P	7a.	BIRTHPLACE (State ar fareign	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED NEVER MARRIED	9. COUNTY OF DEATH	
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ban with	L	MILLERSVILLE,	give street address) KNOL CWOOC	NURSING HOME	TOT OF TAKE Blite, even it refired	INDUSTRY SERVICE
ed plet car ent,	13a.	USUAL RESIDENCE (Where decease	d lived, if institution: Residence before	13c. CITY OR TOWN 13d, INSIDE CIT		
cam ove	dull	ission) STATE Maryland	13b COUNTY Anne Arundel	Gambrills YES	NO BOX #156	
eme an)	14.	ATHER'S NAME First	Middle Last	15. MOTHER'S MAIDEN NAME		2001
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cate sicia secia secia no an		(If yes give we)	r or dates of service)		Address	
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s be as brians	CERTIFICATION	19a. DATE OF OPERATION 19b. Co	ONDITION FOR WHICH OPERATION WAS PE	RFORMED 20a. AUTOPSY?	20b. IF YES, WERE FINDING CAUSES OF DEATH?	S CONSIDERED IN CERTIFYING
The raff	RTIF			YES NO		
AN: ol al cate ar t		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. Month Day Year	21c. HOW INJURY OCCURRED (En	ter nature of injury in Part 1 or Part	2, Item 18.)
Signature of the state of the s	MEDICAL	(If either, natify medical examine	er) P.M.			
G PHYSICIAN: The law rethe haspital ar attending this sertificate has been detached far use as the e Dept. af Health priar ta	>	21d. INJURY OCCURRED Value Nat while 21e. P	LACE OF INJURY (AT HOME, FARM, STREET, FAC	TORY,) 21f. LOCATION Street or R.F.D. I	Na. City ar Tawn	Caunty State
the D det		at walk at walk				
by the by the Affer the be de State		22a. I certify that (I) (this	hospital) attended the decease	ed from 29 Dec, 19.	67, to 31 Dec.	19 6 7, that (I) (we) last
A ATTEND retained recTOR: Al 3 shauld I		couses stoted obave.	(I) (we) (did) (did nat) view the	ed from 2 9 Dec., 19. 96 7, ond that in (my) (our) o bady after death.	pinian death occurred on the	date and haur and from the
A S S S S S S S S S S S S S S S S S S S		22b. SIGNATURE	0 . 1		2	2c. DATE SIGNED
OR Se 3		Charle	elina	DEGREE PHYS.	MED. STAFF DIRECTOR PHYS.	2 Jan 1968
may be RAL DIRI , page 3 be filed v		22d. PHYSICIAN'S		22e. ADDRESS		
SPIT TERA Gr, I		NAME(Type)Charle	s W. Kinzer	Annap	olis, Maryland	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haprs after death. Page 4 may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filed metal director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban pagers. Pages 1 and 2 should be filed with the State Dept. at Health priar ta burial, crematian, ar remaval, and in any event, within 72 hadrs after death.	23a	BURIAL, CREMATION, 23b. DA		CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(Caunty) (State)
22254	E	REMOVAL (Specify)	N. 3,1968 Trini	ty Meth. Ch. Cem		A.A. Co., Md.
VR AIS(I)	24.	FUNDERAL DIRECTOR	SINGLETOMODRES	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 0	R'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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d. NAME OF HOSPITAL OR INSTITUTION (if not in	hospital, give streat addrass)	d. STREET ADDRESS	a. IS RESIDENC
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NAME OF First	Middle	Last 256 Carrell Rd. Mo	nth Day Yaar
(Typa or print) HERMAN	410	RUNOD Sr. DEATH 12	1 10/2
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0a. USUAL OCCUPATION (Give kind of work dona during most of working life, avan if ratirad)	. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country	y) 12. CITIZEN OF WHAT COUNTR
chauffeur	Steel Co.	Mt. Airy, Maryland	U.S.
. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John E. Norwood		Clementine Gatrell	
. WAS DECEASED EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO. 17. II	VFORMANT Addr	Manual 1
fas, no, or unkown) (Ifyesgivawarordatasofsarvica)			rarytand
No	212-07-55454 Her	man Norwood, Jr., 9112 Wal	lden Rd., Silver S
18. CAUSE OF DEATH [Enter only one cause p	par line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:	TE CARDIO-RESI	RATORY FAILURE	SUDDEN
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PART II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT NO	RELATED TO THE TERMINAL DISEASE CONDITION O	SIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
MRTERIOSCLERGT	L HEART D	ISEASE	YES NO
20a. ACCIDENT WAS UNDERLYING [] 20b.		(Enter nature of injury in Part I or Part II of itam 18.)	1
OR CONTRIBUTING CAUSE OF DEATH			
	A INTRIBY OCCUPAND 1 20 NA	OF DEBUTERY (Harman Samuel 2006 (City)	(6
		E OF INJURY (Home, farm, 20f. (City or town) ry, street, office bldg., atc.)	(County) (Stata)
p.m. 19 at	work at work		
21. I certify that (I) (this bosnital) at	tended the deceased from	JUNE 19, 1961 10 DEC 1	1967, that (1) (sum) la
	1	death occured a 9.14.M, from the cause	
22a. SIGNATURE	, and mar	death occured any	s and on the date stated above
A HALL O	249	ATTENDING MED. STAFF	SIGNI
Cerum amojora n	M.I		12-1-67
NAME (Typa)	J.K., Wi. D.	22d. ADDRESS	
PASADENA, MD.			
3a. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY C	R CREMATORY 23d. LOCATION (City,	lown or county) (Stata)
REMOVAL (Spacify)	Daniel Dia		
Birial 12-4-1967	Druid Ridge	2Sa. REC'D BY REGISTRAR 2Sb.	Baltimore, Md.
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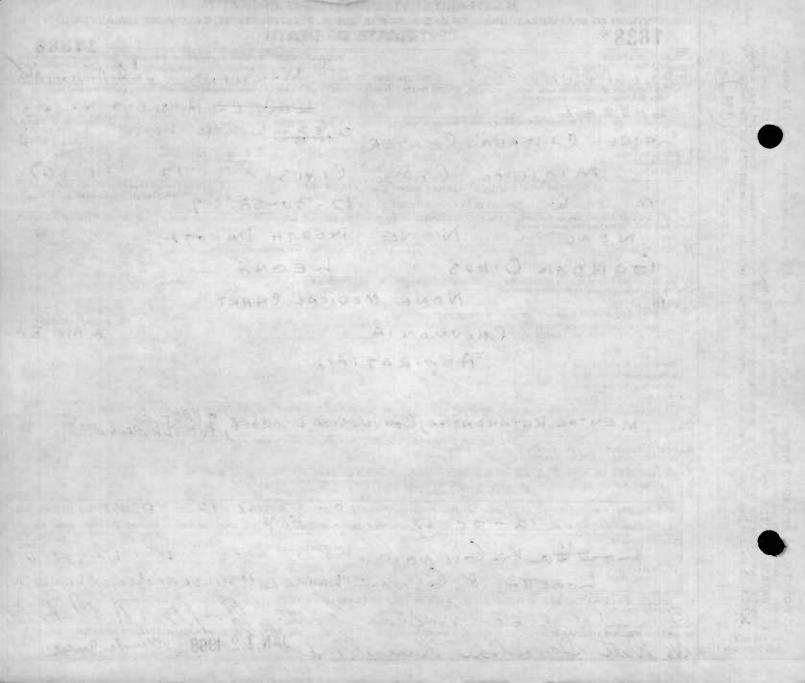
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16386 CERTIFICATE OF DEATH funerol or death. requires that the death certificate be executed within 24 hours after death. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) a. COUNTY STATE b. COUNTY ANNE MARYLAND MARYLAND by III. Pages b. CITY OR TOWN (If outside carporote limits c. LENGTH OF STAY IN 1b c. CtTY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) BURNIE SALTIMORE 21218 FLEN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) .⊆ d. STREET ADDRESS e IS RESIDENCE ON A FARM? 3805 OLD YORK KD ONVALESCENT NO P NAME OF First 4. DATE remove corbon Middle 1 ast Month Doy Yeor DECEASED JARY RIEN (Type or print) DEATH SEX 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED DATE OF BIRTH Months lost_birthdoy) Doys Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? WILMINGTON. TIMEKEEPER
13. FATHER'S NAME U.SA BALTO-TRANSIT CO. 14. MOTHER'S MAIDEN NAME removol, JAMES SARAH BONER 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO signed by the ottendi burial-transit permit. (Yes, no, or unknown) (If yes give wor or dotes of service) SAME MRS. AGNES CURRENS 3-10-98301 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) MTERVAL BETWEEN DNSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO widen Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO stoting the underlying couse be detoched for use as the Stote Dept. of Health prior to **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law Page 4 may be retained by the hospital or ottendin PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES [NO TO FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m Not While foctory, street, office bldg., etc.) ot work of work 21. I certify that (I) (this hospital) ottended the deceased from 20 196 ploods 137 AM, fram causes and an the date stoted above. saw the deceased alive an 19 (5) and that death accurred at 22o. SIGNATURE 22b. DATE SIGNED filed v M.D. DIRECTOR PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S director, po NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) Burial (Specify) New Cathedral Baltimore. Maryland 12/15/67 & Sons Co. 4905 York Road 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) Baltimore. Md. 21212 25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH



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PHYSICIAN:

6- mont 19. WAS AUTOPSY PERFORMED? NO X (State) 2] I certify that (1) (this hospital) attended the deceased from Decarte 10, 1967, to Decarte 15, 1967, that (1) (we) last saw the deceased olive an Decemen 15 196), and that deoth occurred at 16,227 M, from couses ond on the dote stoted obove. 22b. DATE SIGNED ATTENDING PHYS. DIRECTOR PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 529 Moderide Vande 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify)
BURIAL Baltimore County, Maryland 12-19-1967 Cedar Hill Cemetery 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Howard H. Hubbard, 4107 Wilkens Ave. 21229

ON A FARM?

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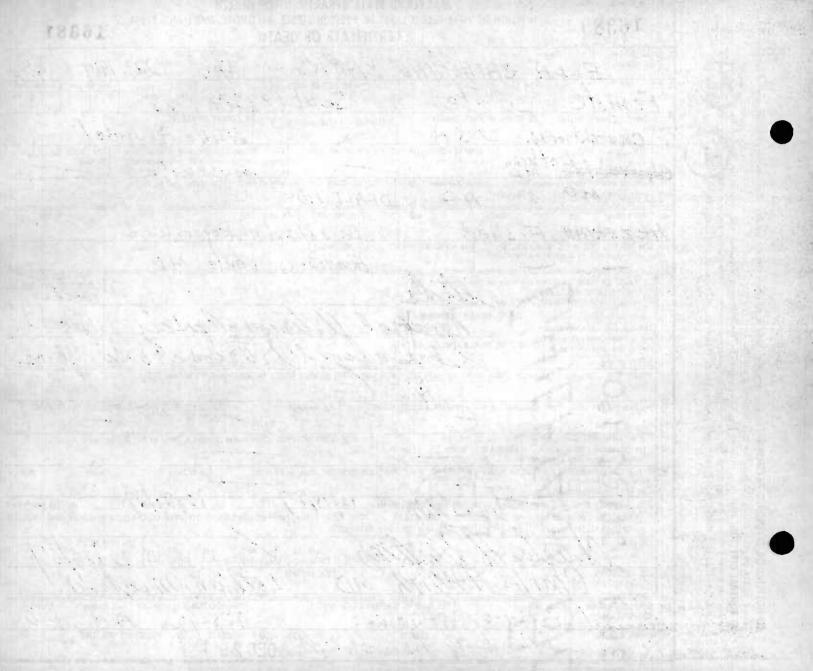
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH CERTIFICATE OF DEATH after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY b. COUNTY Maryland Anne Arundel Anne Arundel MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours Orchard Beach Orchard Beach d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE Tilled ON A FARM? 21226 7812 Waterview Drive 7812 Waterview Drive 21226 YES ND completely within with 3. NAME OF Middle DATE Month Day DECEASED event, Frederick Henry Pepersack 67 (Type or print) DEATH December 15. 19 executed 5. SEX AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS | Jast birthday) | Months | Days | Hours | Min. and cor 6. COLOR OR RACE 8. DATE OF BIRTH 9. 7. MARRIED NEVER MARRIED any Male White June 29, 1898 DIVORCEDAT WIDOWED lease re-1Da. USUAL OCCUPATION (Give kind of work done 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT certificate be during most of working life, even if retired) INDUSTRY Baltimore, Maryland Int. Bedding 60. Machinist removal, 13, FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frederick Wm. Pepersack Lena Meyer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address has been signed by the attent as the burial-transit permit. (Yes, no, or unkown) (If yes give war or dates of service) death Mrs. Margaret Gunther 7825 Bridge Dr. 21226 No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN PHYSICIAN: The law requires that the the hospital or attending physician. ONSET AND DEATH PART 1. DEATH WAS CAUSED BY:

1MMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last, (c) CERTIFICATION 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) of Health p PERFORMED? is certificate none NO X YES 20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE DF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (Clty or town) (County) TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. After Not While be retained by at work at work 0 21. I certify that (I) (this hospital) attended the deceased from 22 195 DIRECTOR: Jage 3 should lied with the saw the deceased alive on Allegarka (1967, and that death occurred at A.M., from the causes and on the date stated above. DATE SIGNED 22a. SIGNATURE 22b. ATTENDING PHYS. page STAFF PHYS. M.D. DIRECTOR 4 may O FUNERAL director, pa ADDRESS PHYSICIAN'S 22d. NAME (Type) LOCATION (City, town or county) NAME OF CEMETERY OR CREMATORY (State) BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 23b. 2 Meadowridge Memorial Park Howard Co. 12/18/67 Burial ADDRESS 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 237 Patapsce Ave. 21225 VR A15 (4) DATE DEC 15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16392 17887 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND and in any event, within 72 hours after b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) 5ALL requires that the death certificate be executed within 24 to d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? NO B pd YES NAME OF First Middle 4. DATE remave carban Month Doy Year DECEASED OF (Type or print) DEATH S. SEX 6. COLOR OR RACE DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED AGE (In years lost birthdoy) Months Dovs Hours Min. WIDOWED K DIVORCED and 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11/BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) attending physician permit. Then please INDUSTRY COUNTRY? TroducteR termon 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, ar remaval, 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (g), (b) and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY neunonia IMMEDIATE CAUSE (o) by physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o). DUE TO stoting the underlying couse attending FUNERAL DIRECTOR: After this certificate has been irector, page 3 shauld be detached far use as the hauld be filed with the State Dept. af Health priar ta PHYSICIAN: The law last. 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? YES NO by the haspital or 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form. (City or town) (County) (Stote) Hour 'o.m. factory, street, office bldg., etc.) Not While O HOSPITAL OR ATTENDING ot work ot work 1960 21. I certify that (1) (this hospital) attended the deceased from 7500 be retained director, page 3 shauld Thought be filed with the LAM, fram causes and an the date stated abave saw the deceased alive an and that death accurred at_ 220 SIGNATUR 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 9 24. FUNERAL DIRECTOR VR A15

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16395 16386 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND Maryland Anne Arundel b. CITY OR TOWN (If outside carporate limits, write RURAL and give negrest town)

Annapol I S c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) Davs Severna Park d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Anne Arundel General Hospital 133 Round Bay Road YES NO.L 3 NAME OF Middle 4. DATE pau Last Manth W Dov Year physician and completely DECEASED Miriam (Type or print) Toombs RAKER DEATH December COL 7. MARRIED IF UNDER 24 HRS 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF LINDER 1 YEAR **NEVER MARRIED** last birthday) Manths Days Haurs and in any White WIDOWED DIVORCED February 20, 1916 Female 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Convwriter Dent.Store COUNTRY? Illinois 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, signed by the attending phy Claude H Toombs Cleo Albin 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, ar unknown) (If yes give wor or dates of service 17. INFORMANT 16. SOCIAL SECURITY NO. Address Fredrick Ra ker burial, crematian, 18. CAUSE OF DEATH (Enter only one cause per line far (1), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gave rise ta immediate cause (a). DUE TO stoting the underlying cause as the has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) (County) Haur a.m. foctory, street, affice bldg., etc.) Nat While of wark at wark O FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram. 19___, that (I) (we) last _ to be retained saw the deceased alive an December 16 19 67, and that death accurred at 9:50 M, from causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. DIRECTOR M.D. 22d. ADDRESS-22c. PHYSICIAN'S NAME (Type) 23b. DATE THEREOF 23G NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23o. BURIAL CREMATION. (Stote) (County) REMOVAL (Specify) EMATION 12-16-6 CREMATORY 11/45HIW9Yow 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 BIABBANCO. PARK. MO DATE

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6396 CEDTIFICATE OF DEATH

24 haurs ofter death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed Poge 4 may be retoined by the hospital or ottending physicion.

	1000			CEKTIFICAL	t OF DEATH		7	0381
1.	PLACE OF DEATH				2. USUAL RESIDENCE (Where deceosed lived, if ins	titution: Reside	ence before admission)
	a. COUNTY	Anna Arunda	1	MARYLAND	a. STATE	b. (COUNTY	
-	b. CITY OR TOWN	Anne Arunde (If autside corparate limit		c. LENGTH OF STAY IN 1b	C CITY OF TOWN (IF a)	yland utside corparate limits, write	Ani	ne Arundel
	write RURAL an	d give nearest town)	,	E. 10.10 (10.15 (10.15))	c. ciri ok lown (ii di			ve nearest tawn)
_	T NAME OF HOOD	Annapolis TAL OR INSTITUTION (If no	42 1 2 1	5 Days		Glen Burn	ie	07-1
					d. STREET ADDRESS			e IS RESIDENCE ON A FARM?
	Anne	Arundel Gen	eral H	ospital	102 Wo	ods Avenue		YES NO
3.	NAME OF DECEASED	Fi Fi	rst	Middle	Lost		Month	Day Year
	(Type or print)	Will	iam	Henry	REDELIUS	DEATH Decem	her	28 1967
	SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF 8IRTH	9. AGE (In yeor	rs IF UNDER	R 1 YEAR IF UNDER 24 HRS
	Male	White	WIDOWED	DIVORCED	May 20, 190	4 leta irthdo	y) Months	Doys Hours Min.
I Oa	. USUAL OCCUPATION	N (Give kind af wark dane	10b. KI	ND OF BUSINESS OR	11. 8IRTHPLACE (County	& Stote, or foreign country)	12 (CITIZEN OF WHAT
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	FATHER'S NAME		- 1 4	eneral motors	14. MOTHER'S MAIDEN			
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15.		rederick	Redeli		INFORMANT	mie Higdon	ddress	
	s, na, or unknown)	(If yes give wor or dotes o	f service)					
	No	1		5-05-0892	Mary N. Rede	lius, same a	s 2	
	PART I. DEA	EATH (Enter only one cou TH WAS CAUSED BY:			1-1			ONSET AND DEATH
	222	IMMEDIATE CAUSE	, ,	Cerebral 1	wan beres			Jour :
	004/	DUE	TO					
	Conditions, if ony rise to immediat	e couse (n)	(b)					
	stoting the unde		10					
	last.)	(c)					
z	PART II. OTHER SI	GNIFICANT CONDITIONS C	ONTRIBUTING T	O DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE COL	NDITION GIVEN IN PART 1(o)	19. WAS AUTOPSY PERFORMED?
ATIC	PI - 1	l						YES NO
CERTIFICATION	20o. ACCIDENT WA		20b. DES	CRIBE HOW INJURY OCCURRED	. (Enter noture of injury in	Part I or Port II of item 18.	.)	
ER I		CAUSE OF DEATH MEDICAL EXAMINER)						
MEDICAL	20c. TIME OF INJU	JRY Month, Doy, Yeor	20d. IN	JURY OCCURRED 20e. PL	ACE OF INJURY (Hame, forn	n, 20f. (City or town) (C	ounty) (State)
ME	Hour 'o.r	10	While of work		ctary, street, office bldg., etc.)		
		11.		ed the deceased from_	12/1/1	967. to 12/2	7 16	77, that (I) (we) lo
	saw the de	ereased alive an D	ecember	r 2819 67, and the	at death accurred at		as and an	the date stated above
	22a. SIGNATURE	/	, ,	Lao I / O. J., dila III	ar depiri decorred di	2:10 a. m.		DATE/SIGNED / .
		Gerand &	hund	M	.D. PHYS.	MED. STAFF DIRECTOR PHYS.		2/29/67
	22c. PHYSICIAN'S	-			22d. ADDRESS			1000
	NAME (Type)		ettune	19 -	121 6	ulterland SI,	men	afolis 1/41
230	. BURIAL, CREMATIC	ON, 23b. DATE THE	DEUE.	23c. NAME OF CEMETERY OF	CDEMATORY	23d. LOCATION (City or	Taun)	(County) (See
200	REMOVAL (Specify)						(County) (Stote)
24	Burial FUNERAL DIRECTO	1 Jan.	. 68	Meadowridge	e Memorial	Elkridge D 8Y REGISTRAR 25b.	REGISTRAR'S	rd, Md.
24			. 03					
	THE KLEY	runeral Hor	ne, Gle	n Burnie, Md.	21061 DATE A	N 2 1968	Lucy	les Judge

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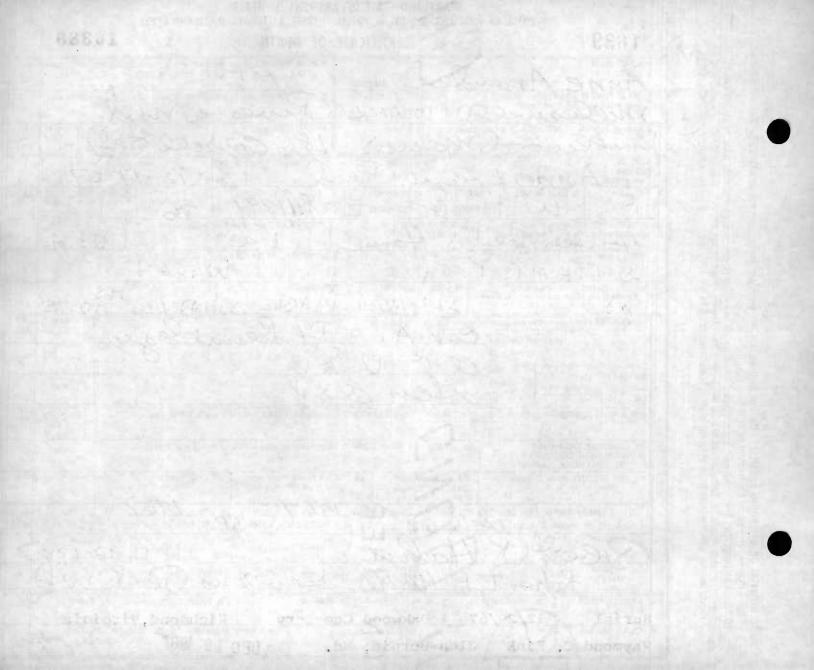
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16397 16388 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death funeral 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY o. STATE b. COUNTY MARY! AND by the tr c. LENGTH OF STAY IN 1b CLETT OR JOWN autside carparate limits, write RURAL and give nearest tawn) SOUS O-WEEKS papers. .= d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? filled within YES NO carban NAME OF Middle DATE Month Day Year completely DECEASED 0 event, (Type or print DEATH IF UNDER 24 HRS S. SEX 7. MARRIED 9. AGE (In years **NEVER MARRIED** lost birthday) Manths Days Haurs and in any WIDOWED DIVORCED and 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. 81RTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of warking life, even if retired **INDUSTRY** COUNTRY ? physician Ozer 13. FETHER'S NAME 14. MOTHER'S MAIDEN NAME d ar removal, NAUGH 6 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) DOVE burial, crematian, INTERVAL SETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for PART I. DEATH WAS CAUSED 8Y: signed by the burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or attending physician. **DUE TO** Canditians, if any, which gave rise to immediate cause (o), DUE TO stating the underlying cause as the has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? far use Health NO this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar town) (County) (State) Haur o.m. While Not While factory, street, office bldg., etc.) After at wark pe 21. I certify that (I) (this haspital) attended the deceased fram_ , that (I) (we) last be filed with the TO FUNERAL DIRECTOR: saw the deceased alive an_ and that death accurred at SPM, fram causes and an the date stated above. 220 SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. DIRECTOR M.D. 22c. PHYSICIAN'S **ADDRESS** O HOSPITAL NAME (Type) directar, shauld b 23d. LOCATION (City or Town) 23a. 8URIAL CREMATION 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY (County) Burial (Specify) Oakwood Cemetory
ADDRESS 25 12/20/67 Richmond. Virginia 24. FUNERAL DIRECTOR 2So. REC'D 8Y REGISTRAR Charles

Glen Burnie. Md.

DATE DEC

VR A15 (4) 25M 1/67

Raymond C. Fink



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 16389 HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Anne Arundel Maryland b. COUNTY 무 MARYLAND delay and 3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Department b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b ping , write RURAL and give nearest town) D.O.A. Annapolis Crownsville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENCE ward "pending" in pencil in Item 18. Give Pages 1, the Chief Medical Examiner's Office alang with farm ON A FARM? State [Anne Arundel General Hospital Rt. 2. Box 606A NO S be executed within 24 haurs after death. NAME OF First Middle RETER lost 4. DATE Month Year DECEASED CLEMENTINE E. RAXIER (Type or print) December DEATH 67 S. SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours after death. Female. White 4/9/1930 WIDOWED DIVORCED fDo. USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSINESS OR 1f. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if refired)
HOUSEWIIE INDUSTRY COUNTRY? Mass. 13. FATHER'S NAME f4. MOTHER'S MAIDEN NAME Walter Galenski Anna Zalesuski File 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no or unknown) (If yes give wor or dotes of service) 030-22-6049 within Edward W. Reier (above address) (Husband) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH event Fatty Alteration of Liver IMMEDIATE CAUSE (o) This certificate shauld e certificate, writing the ward shauld be farwarded ta the C DUE TO dny Conditions, if ony, which gove rise to immediate couse (a). = DUE TO stoting the underlying couse and and PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? remaval, YES X NO 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 3 shauld PRIMARY Or CONTRIBUTING crematian, or CAUSE OF DEATH. 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED (City or town) (County) (Stote) foctory, street, office bldg., etc.) FUNERAL DIRECTOR: Page ot work please execute 21. I certify that I took charge of the remains described above, held on Autopsy [X] Inspection | Inquiry ond in my opinion death resulted from: Natural causes X. Accident Suicide . the funeral directar. Homicide Undetermined manner CHIEF MEDICAL EXAMINER Health priar to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER K SIGNATURE DEPUTY MEDICAL EXAMINER 12/10/67 **EXAMINER'S** Werner U. Spitz, M.D. may NAME (Type) Address (Street, city, town, or county) 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 0 REMOVAL (Specify)
Burial Fort Lincoln Cem 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Nalley's Funeral VR A15ME (5) Home Charle 6M 1/67 Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

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	PLACE OF DEATH •. COUNTY		2. USUAL RESIDEN	CE (Where dece			nce before	e dmission
	Anne Arundel	MARYLAND	. STATE Maryla	nd	b. COUNT	nne Arui	del	
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (vn)
	West River		Rural	West R	i	13-	,	
	d. NAME OF HOSPITAL OR INSTITUTION (if not in	hospital, give street eddress)	d. STREET ADDRESS	Hest It	TAGL	0 # -	l e. IS R	ESIDENCE
							ON	A FARM?
3.	Residence West River						YES	NO X
	DECEASED (Type or print)	Middle	Last	4. DATE OF	Month	Dey	Yea	r
_	ETHEL	MARIE	RENEHAN	DEATH	Dec.	27	19	67
5.	SEX 6. COLOR OR RACE 7. MA	RRIED NEVER MARRIED B	, DATE OF BIRTH	9.	AGE (In yeers lest birthdey)	IF UNDER 1 YEAR	IF UNDER	
	female Caus. WIDO	OWED DIVORCED	July 29, 1897	7	70 yrs.	Months Deys	Hours	Min.
100		. KIND OF BUSINESS OR INDUSTR		ty & State, or for	10	12. CITIZEN	OF WHAT	COUNTRY
		milh 74 a m427242	W	۵		TICA		
13.	telephone operator	public utilitie	es Marylar	NAME		USA		
15.	Bernard Norris	16. SOCIAL SECURITY NO. 17. 1	NFORMANT Lelia	Hayden	Adden			
(Ye	es, no, or unkown) (Ifyes give werordetes of service)				Address	3 3 7		
	no	577 011 617 Ja	mes J. Rener	nan - sar	ne as #	2 above		
	IB. CAUSE OF DEATH [Enter only one ceuse p	per line for (e), (b), and (c),	. 0 ,			I IN	MENTAL BE	TWEEN DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	yecordial i	njarction	r		16	ow bu	are
	4201 DUE TO 1	1 - 0 0	10	- 1		0		
	Conditions, if any, which \ (b)	rterioschroft	& Kear	t dise	are		year	VL
	geve rise to immediate cause							
	(e), steting the underlying DUE TO							
z	(e), steting the underlying DUE TO	CONTRIBUTING TO DEATH-BUT NO	E RELATED TO THE TERMIN	VAL DISEASE CO	NDITION GIVE	FN IN PART 1(a)	10 WAS	VZGOTILA
HON	(e), steting the underlying DUE TO	CONTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMIN	NAL DISEASE CO	NDITION GIVE	EN IN PART 1(e)	PERFC	DRMED?
ICATION	(e), steting the underlying DUE TO couse lest. PART II. OTHER SIGNIFICANT CONDITIONS Of CONDITIONS	- doft	uenza			EN IN PART 1(e)	19. WAS A PERFO	AUTOPSY DRMED?
RTIFICATION	Column C	CONTRIBUTING TO DEATH BUT NO DESCRIBE HOW INJURY OF CURRE	uenza			EN IN PART 1(e)	PERFC	DRMED?
CERTIFICATION	(e), steting the underlying DUE TO couse lost. PART II. OTHER SIGNIFICANT CONDITIONS Of the condition	- doft	uenza			EN IN PART 1(e)	PERFC	DRMED?
	Ce), steting the underlying DUE TO	DESCRIBE HOW INJURY OCCURRED	D. (Enter nature of injury in	Pert I or Part II	of item 1B.)	EN IN PART 1(e)	PERFC	DRMED?
	Ce), steting the underlying DUE TO	DESCRIBE HOW INJURY OCCURRED Dd. INJURY OCCURRED About the part of the part	D. (Enter nature of injury in	Pert I or Part II	of item 1B.)		PERFC	NO [
MEDICAL CERTIFICATION	Ce), steting the underlying DUE TO	DESCRIBE HOW INJURY OCCURRED Dd. INJURY OCCURRED 200. PLA fect work et work	CE OF INJURY (Home, form ory, street, office bldg., etc.	n Pert I or Part II	of item 1B.)	(County)	YES T	NO (Stete)
	Ce), steting the underlying DUE TO	DESCRIBE HOW INJURY OCCURRED 200. PLA fect work et work tended the deceased from.	CE OF INJURY (Home, fermory, street, office bldg., etc.	20f. (City of	of item 18.) r town)	(County)	PERFC YES That (I)	(Stete)
	Ce), steting the underlying DUE TO	DESCRIBE HOW INJURY OCCURRED 200. PLA fect work et work tended the deceased from.	CE OF INJURY (Home, form ory, street, office bldg., etc.	20f. (City of	of item 18.) r town)	(County)	PERFO YES	(Stete) (we) la
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WEDICAL 236	Ce), steting the underlying DUE TO	DESCRIBE HOW INJURY OCCURRED 200. PLA feet work et work tended the deceased from 12.0	D. (Enternature of injury in CE OF INJURY (Home, formory, street, office bldg., etc.) D. ATTENDING APHYS. DR CREMATORY SOTTOWS	19.0.7 to	of item 1B.) In town) The causes a STAFF PHYS. SIDE ON (City, townsville	(County) 1. 1967, and on the day an or county)	that (I) date stated	(State) (State) (we) la: above DAJE SISNEI

MARYLAND STATE DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH 6391 funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Whara deceased lived, If institution: Rasidance before admission) a. COUNTY a. STATE b. COUNTY ANNE ARUNDEL MARYLAND ANNE ARUNDEL MARYLAND the d b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 þ writa RURAL and give naarast town) PASADENA **PASADENA** d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? RT. BOX 419 2 BOX 419 YES NO X papers 4. DATE 3. NAME OF First Middla Last Month Day Year complete DECEASED OF CHARLES ROCK DEATH (Typa or print) V. 67 19 carbon with 9. AGE (In years | IF UNDER 1 YEAR 5. SEX 6. COLOR OR RACE 7. MARRIED K NEVER MARRIED 8. DATE OF BIRTH IF UNDER 24 HRS. last birthday) and Months Days Hours Min. MALE WHITE WIDOWED | DIVORCED 5-10-94 73 10a. USUAL OCCUPATION (Give kind of work physician 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? dona during most of working life, avan if ratirad) BALTO, CITY USA TEACHER. RETIRED MARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME affending CHARLES V. ROCK MC DERMOTT ANNIE E. a 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Addrass (Yas, no, or unkown) | (Ifyasgiva war or dates of sarvica) ELLA A. ROCK, Rt. 2 Box 419, Pasadena, Md. 214405569 18. CAUSE OF DEATH [Enter only one causa per lina for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH NERALIZED CARCINOM ATOSIS PART I. DEATH WAS CAUSED BY: MO IMMEDIATE CAUSE (a) signed burial-transit (b) CARCINOMA PROSTATE aftending Conditions, if any, which gava rise to immadiata causa DUE TO (a), stating the undarlying certificate has I or use as the buriel, prior to burial, causa last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO . 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of itam 18.) 20a. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ATTENDING be retained by After 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Homa, farm, 20f. (City or town) (County) (Stata) 20c. TIME OF INJURY Month, Day, Yaar factory, street, offica bldg., etc.) Whila Not Whila Hour a.m at work at work ECTOR: 1963 to DEC 30 1967, that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from JULY 30....., 2.3 1967..., and that death occured alf. 4.M, from the causes and on the date stated above. 22b. DATE 22a. SIGNATURE ATTENDING SIGNED arthur 12-30-67 DIRECTOR PHYS. M.D. HOSPITAL death. Page 4 page with t 22d ADDRESS 22c. PHYSICIAN'S UR LANKFURD JR. MD. 2934 MOUNTAIN director, be filed 23d. LOCATION (City, town or county) (Stata) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 1-1-68 DRUID RIDGE CEMETERY BALTIMORE, MD. TO BURIAL 25a. REC'D BY REGISTRAR 25b. REGISTRAD'S SIGNATU 24 FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** VR A15 (4) HOWARD H. HUBBARD 4107 WILKENS AVE. 21229 15M 9/60

law requires that the

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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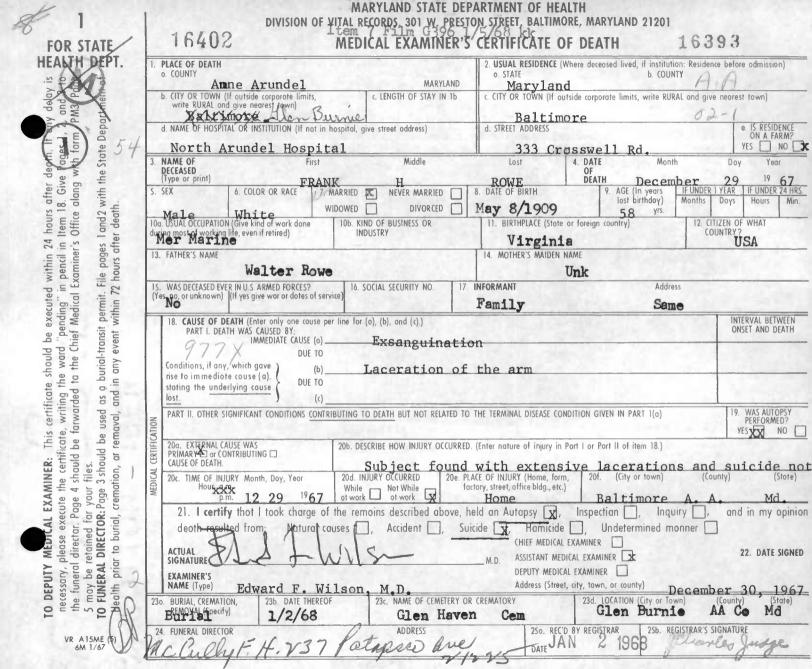
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			MARYLAND STATE DEPARTMENT OF HEALTH
			16401 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	0.		CERTIFICATE OF DEATH 16392
<u>-</u> : _	NO		CEASED-NAME First Middle Lost 2a. DATE OF DEATH 2b. HOUR
leat eat	eat	(1-	pe or print) (ha) (es W. Koss / Month 2015 Year 7 M
Je Je	er	3. SE	4. BACE S. DATE OF BIRTH 6. AGE (In years IF UNDER YEAR IF UNDER 24 HRS.
£ /\$	oges rs att	7	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
haur in by		7a. B	IRTHPLACE (Stote of foreign 77b, CHIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED DIVORCED DI
n 24	dod	10.0	TY OR TOWN/OF DEATH
withi ely f	E . 3	0	Market Line Several Actives
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death be retained by the haspital or attending physician. SIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the examenal	event.	13o. admi	JSUAL RESILENCE (Where deseased lived, if institution: Residence before 13t. CITY OR TOWN 13d. INSIDE CITEDIANTS? 13e-STREET AND NUMBER 13b. COUNTY 15b. COUNTY 15
exec	any	14. F	ATHER'S NAME First Middle Lost
e be	nd in	14.	VAS DECEASED EVER IN U.S. ARMED FORCES? 116b. SOCIAL SECURITY NO. 117. INFORMANT Address
ifficat	burial-transit permit. Then please remove car burial, crematian, ar remaval, and in any event	16d.	VAS DECEASED EVER IN U.S. ARMED FORCES? Ind. grunknown) (If yes give wor or dolles of service) 219-12-3265 Prome Ardress Ardress Ardress
cert g p	Ther		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c);) APPROXIMATE INTERVAL BETWEEN ONSET AND GRAPH
eath ndin	burial, crematian, ar rem		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CINCLE CINCLES
ne de	pern an,		DUE TO, OR AS A CONSEQUENCE OF
the the	mat		Conditions, if any, which gave rise to immediate cause (a), (b)
The law requires the attending physician. has been signed by	-trair , cre		stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF
uires nysic	rial		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
g pl	e br		TAKE 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO BEATT BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION OF THE TER
aw ndin beel	d t	TION	190, DATE OF OPERATION 196, CONDITION FOR WHICH OPERATION WAS PERFORMED 200, AUTOPSY? 206, IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
The law ratending has been	h pri	CERTIFICATION	YES \ NO \ \ NO \ CAUSES OF DEATH?
or or	SE		21a. ACCIDENT WAS UNDERLYING 121b. TIME OF INJURY 121c HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 2 Item 18.)
E le	P H	MEDICAL	Or Contributing Cause of Death HOUR A.M. Manth Day Year (If either, notify medical examiner) P.M.
OR ATTENDING PHYSICIAN: be retained by the haspital or DIRECTOR: After this certificate	achec ept. c		21d INIJIRY OCCURRED 21e PLACE OF INIJIRY (AT HOME, FARM, STREET, FACTORY,) 21f IOCATION Street or R.F.D. No. Gity or Town County State
G P	det te D		While Not while the North Work of Work
by Affe	Sta		22a. I certify that (I) (this haspital) attended the deceased fram, 19, ta, 12, that (I) (we) last saw the deceased alive an19, and that in (my) (aur) apinian death accurred an the date and haur and fram the
TEN ined	the		causes stated above, (I) (we) (did) (did not) view the bady after death.
Tetal ECTO	with		22b. SIGNATURE DEGREE PHYS DISPETOR DIS
L of be	ede		DEGREE PHYS. DEGREE PHYS. DIRECTOR DI
TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the haspital or O FUNERAL DIRECTOR: After this certificate	director, page 3 shauld be detached for use as the should be filed with the State Dept. of Health priar to	N/	NAME (Type) ALEN 226. ADDRESS
HOS ge 4	noulc	23a.	BURIAL, CREMATION 23b. DATE 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) ((County) . (Stote)
5 P 5	一方方	E	will 121286 100 11 10 with the control of the
	VR ATE (24	ADDRESS 250. REGISTRAR 5 JGNATURE
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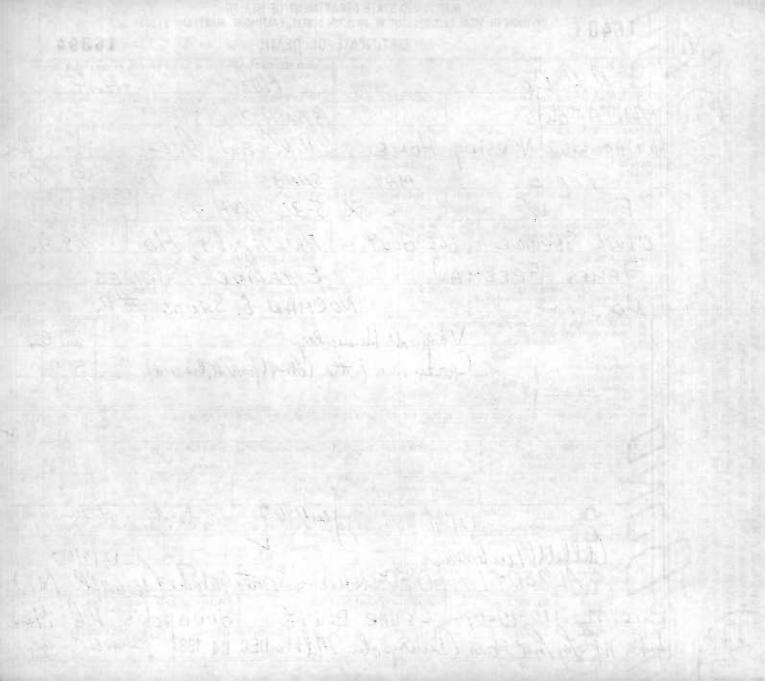
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D. Will MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16403 CERTIFICATE OF DEATH 16394 that the death certificate be executed within 24 hours ofter death deor the funerol PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY MARYLAND b_CITY OR TOWN (If autside carparate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give negrest tawn) write RURAL and give negrest town) Dhis d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) .= d. STREET ADDRESS e. IS RESIDENCE ON A FARM? completely filled NURSING GN.GLER ond in any event, within NOR YES NAME OF Middle 4. DATE Last Manth Year DECEASED SANdS (Type or print) EFF 1C DEATH 6. COLOR OR RACE 7. MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Months Hours WIDOWED DIVORCED and 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT physicion a during mast of working life (even if retired) 11112 13. FATHER'S_NAME or removal, attending p permit. The 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, of unknown) (If yes give war ar dates of service cremation, 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN the signed by the buriol-transit buriol, cremati PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) ottending physician. DUE TO Canditians, if any, which gave rise ta immediate cause (a). DUE TO stating the underlying cause the prior to hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19. WAS AUTOPSY PERFORMED? for use Health NO by the hospitol or TO FUNERAL DIRECTOR: After this certificate TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital or for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 ar Part II af item 18.) 20g. ACCIDENT WAS UNDERLYING be detoched for State Dept. of H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Haur a.m. Nat While factory, street, affice bldg., etc.) at wark 21. I certify that (I) (this haspital) attended the deceased fram 7 that (1) (we) last saw the deceased alive an and that deoth occurred fram causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS. filed M.D. DIRECTOR PHYS director, poge should be filed 22c. PHYSICIAN' NAME (Type) BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4 25M 1/67



	16404	CERTIFICA	TE OF DEAT	H	6395
1.	PLACE OF DEATH a. COUNTY			ICE (Whare dacaased lived, If institutions	
	Anne Arundel	MARYLAND	* Maryland	d Anne	Arundel
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest lown)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN ((If outside corporeta limits, write RURAL e	nd giva naarast town)
		14 yrs.	Pasader		02/
	d. NAME OF HOSPITAL OR INSTITUTION (if not in he	ospital, give streat addrass)	d. STREET ADDRESS		e. IS RESIDEN
	9 Winding Woodsway			ng Woodsway	YES NO
3.	NAME OF First DECEASED	Middla	Last	4. DATE Month	Day Year
	(Typa or print) PAUL		SCHAFER	December December	14 19 67
5.	SEX 6. COLOR OR RACE 7. MARR	HED NEVER MARRIED B	. DATE OF BIRTH	9. AGE (In years IF UNDER Months	
	ale White WIDOW		21 Oct 1924	43 yrs.	Days Hours Min
10	a. USUAL OCCUPATION (Give kind of work one during most of working life, evan if ratirad)	KIND OF BUSINESS OR INDUSTR	Y 11. BIRTHPLACE (Cour	nty & State, or foraign country) 12. Cl	ITIZEN OF WHAT COUN
	Pipefitter F.	M.M. Inc. Co.	Baltimore	e, Maryland	U.S.A.
13.	FATHER'S NAME		14. MOTHER'S MAIDEN	NAME	
	Paul H. Schafer		Anto	oirie Rosenboom	
15.		S. SOCIAL SECURITY NO. 17.	NFORMANT	Address	THE REAL PROPERTY.
		216-20-7305 Pe	arl F. Schai	fer - Wife - Same	as # 2
	18. CAUSE OF DEATH [Enter only one cause par				ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	neum onia			2 day
	154 X DUE TO	^			
	Conditions, if any, which (b)	Fremia			3 mos
	gave rise to immadiata cause (a), stating the underlying DUE TO	^ /)			
	cause last.	A of K	ECTUM		18 mo
NO	PART II. OTHER SIGNIFICANT CONDITIONS CO	ONTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERMI	NAL DISEASE CONDITION GIVEN IN PAR	RT 1(a) 19. WAS AUTO
ATI					YES NO
CERTIFICATION	208. ACCIDENT WAS UNDERLYING 206. D	ESCRIBE HOW INJURY OCCURRE	D. (Entar natura of injury is	n Part I or Part II of item 1B.)	
S.	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
MEDICAL		. INJURY OCCURRED 200. PLA	CE OF INJURY (Home, farr	m, 20f. (City or town) (Co	ounty) (State
MEDI	Hour a.m. Whi	1101 1711110	ory, straat, offica bldg., atc	··)	
	21. I certify that (i) (this hospital) after		JAN	19 60 to DEC 19	67 that (1) (
	saw the deceased alive on DEC 1	3 10 67 and that	death accurred at 4	PM from the causes and on	the date stated abo
	22a. SIGNATURE	417	deall occurred ar.x.	, from the causes and on	22b. DA
	1.5.0 H	10	D. PHYS.	MED. STAFF DIRECTOR PHYS.	SI
	22c. PHYSICIAN'S	<u> </u>	22d. ADDRESS		12-15-
	NAME (Type) C. Earl Hill,	M. D.	395 Ft. S	mallwood Rd., Pasad	dena, Md. 21
	a. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY		23d. LOCATION (City, town or cour	
22	PEMOVAL (Specify)	Glen Haven M		Glen Burnie, M	
_	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		C'D BY REGISTRAR 25b. REGISTRAR'S	
8					
24	Singleton Funeral Home/				

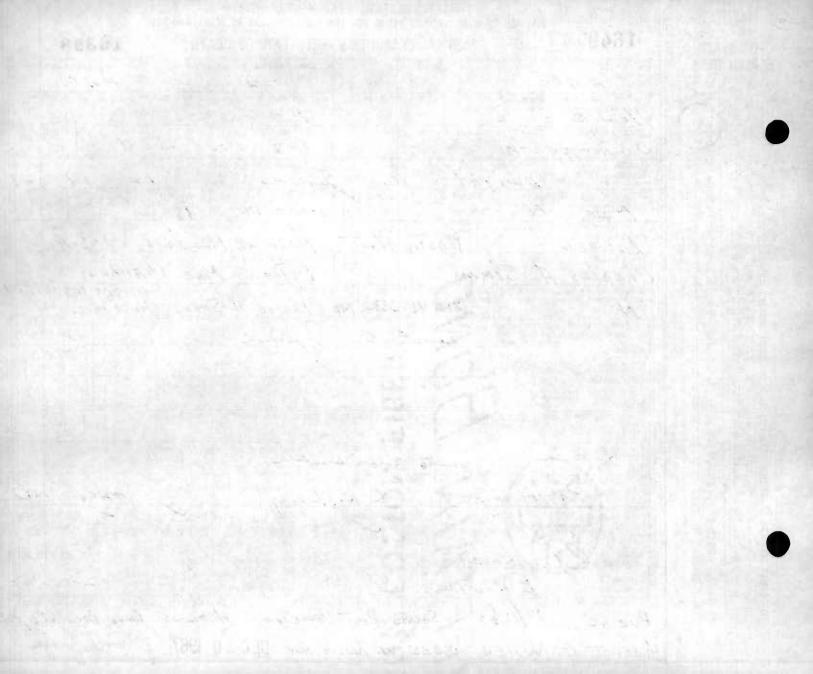
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16405 CERTIFICATE OF DEATH deoth. ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours ofter death pup the funerol PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel Maryland Anne Arundel ours other MARYLAND Pages b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood Forest Annapolis .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS within 72 Anne Arundel General Hospital 715 Robin Hill NO NO YES 3. NAME OF corban First Middle DATE Doy Year completely DECEASED OF DEATH December (Type or print) Lysander SCOTT 19 67 Frank SEX IF UNDER 1 YEAR 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED remove birthdoy) Months Doys Hours or removal, and in any White WIDOWED X Male DIVORCED October 21,1883 puo 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician or duting most of working life, even if retired COUNTRY? STORE lowa 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ULLOUGH 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, grunknown) (If yes give war or dates of service) BERTRAM SCOTT # 1 signed by the otten burial-tronsit permi buriol, cremation, o 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN 4 ONSTAND DEATH Myocardial infarction IMMEDIATE CAUSE (o) the hospitol or attending physicion. DUE TO many Arteriosclerosis Conditions, if ony, which gove vears rise to immediate couse (a), DUE TO stating the underlying couse prior to hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? ed for use to Septicemia due to ileus. Ileus due (a) above. YES TO NO O FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (Stote) (County) Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work Poge 4 may be retained by 21. I certify that (I) (this haspital) attended the deceased from Aug 19, 1966 to Dec 23 19 6 / that (I) (we) last 1967 saw the deceased olive an Dec 23 , and that death occurred at 7:2244, from couses and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS. Dec 24, 1967 M.D. director, poge should be filed Murray Avenue 22d. ADDRESS 16 NAME (Type) Charles W. Kinzer, M. D. Annapolis, Maryland 21401 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (County) (Stote) PINE GROVE UNITED 24. FUNERAL DIRECTOR REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH 16406 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16397 CERTIFICATE OF DEATH Middle Last 2o. DATE OF OEATH funeral s T and 2 ter death DECEASED-NAME First 2b. HOUR (Type or print) Theodore M. Seal 2:00% 3. SEX 4. RACE S. DATE OF BIRTH 6. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last bighday) OAYS HOURS purial-transit permit. Then please remove carban papers. Page burial, crematian, ar remaval, and in any event, within 72 haurs al White 10/28/16 Male hours 9. COUNTY OF DEATH 7b. CITIZEN OF WHAT COUNTRY? 7a. BIRTHPLACE (State or foreign 8. MARRIED NEVER MARRIED county)irginia USA WIDOWED DIVORCED [Anne Arundel filled 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12o. USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR be executed within "Trownsville State Hosp. during most of working life, even if retired.) INDUSTRY Crownsville 130. USUAL RESIDENCE (Where deceased lived, if institution; Residence before 13c. CITY OR TOWN 13e. STREET AND NUMBER 13d. IHSIDE CITY LIMITS? odmission) STATE 30 13b. COUNTY NO T Baltimore 5605 Denwood Avenue 14. FATHER'S NAME Middle Last 1S. MOTHER'S MAIDEN NAME First Lost and Theodore Seal Annie Hicks attending physician or nermit. Then please OR ATTENDING PHYSICIAN: The law requires that the death certificate 160, WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO 17. INFORMANT Yes, no, or unknown) Hospital Records, Crownsville Maryland Unknown 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) BETWEEN OHSET AND DEATH PART I. DEATH WAS CAUSED BY Septicemia IMMEDIATE CAUSE (o) DUE TO, OR AS A CONSEQUENCE OF Canditions, if any, which gove Urinary Tract Infection rise to immediate couse (a). signed by DUE TO, OR AS A CONSEQUENCE OF Page 4 may be retained by the hospital ar attending physician. stating the underlying couse last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) **D FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. of Health priar ta Hypertension. Peptic Ulcer 19a, DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO 🔽 YES 21a. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) OR CONTRIBUTING CAUSE OF CEATH HOUR A.M. Month Day Year (If either, notify medical examiner) P.M 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. 21d. INJURY OCCURRED City or Town County State While Not while at work 22a. I **certify** that (1) (this haspital) attended the deceased from 12/9 , 19_67, ta___12/29 , 19_67, that (1) (we) last saw the deceased alive an 12/29 ____19_67, and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death 22c. DATE SIGNED 22b. SIGNATURE ATTENDING STAFF 12/29/67 DEGREE DIRECTOR PHYS. PHYS. 22e. ADDRESS 22d. PHYSICIAN'S NAME (Type) Benedict, M.D. Crownsville State Hosp., Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b. OATE (County) (State) REMOVAL (Specify) Baltimore Maruland 0 2500 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNAT FUNERAL OIRECTOR 30M REV. 168 John A. Moran, Inc. 3000 E. Balto. St. Balto 1968 DATE A A

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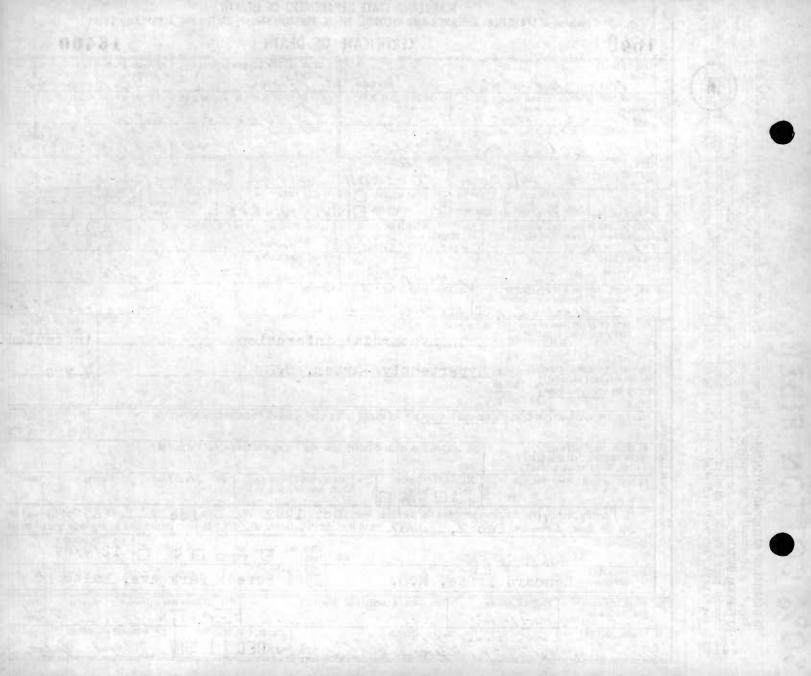
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16407 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16398 FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY delay is ond 3 to Page ACO MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) puo write RURAL and give nearest tawn) HANOVEK ew BURNI poges lond 2 with the State Depart d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE 4 should be forwarded to the Chief Medical Examiner's Office olong with form ON A FARM? Post-Rop 109 · A - NOKTH be executed within 24 hours ofter death. Il "pending" in pencil in Item 18. Give Pages NO X NAME OF , Last Year DECEASED IMM S 19 6 7 (Type or print) DEATH S. SEX AGE (In years IF UNDER IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) event within 72 hours ofter death. DIVORCED WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) ADOREN HARMONS, LASIC LA41 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME permit. File Address Box 109 Post Rd IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 217-46-3332 Mp. Charles HANOVER, Md 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-tronsit ONSET AND DEATH IMMEDIATE CAUSE (o) This certificate should writing the word DUF TO in ony Conditions, if ony, which gove rise to immediate cause (a), DUE TO stoting the underlying cause 19. WAS AUTOPSY PERFORMED? or removal, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO be 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) 3 should PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED _> 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) YOUR While Not While factory, street, office bldg., etc.) of work p.m. 12-14 196 21. I certify that I took charge of the remains described above, held an Autopsy Inspection and in my apinian death resulted from: Natural causes Accident 4 Suicide Homicide Undetermined manner be retoined CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED prior ASSISTANT MEDICAL EXAMINER SIGNATURE M.D. DEPUTY MEDICAL EXAMINER **EXAMINER'S** moy Health Address (Street, city, town, or county) 23o. BURIAL CREMATION 23d LOCATION (City or Town) 2 BURIAC (Specify) HARMONS .- HUNE HRUNDECO 24. FUNERAL DIRECTOR VR A15ME (5 3035 W. North Ave DADEC



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 16399 PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY delay is ond 3 to M3. Page A.A.Co MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.M3. HANOVERd. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) re Dep d. STREET ADDRESS e IS RESIDENCE ON A FARM? form in Item 18. Give Pages 1, 109 Puch Road DOA-NORTH. ARUNDEL HOS YES NO 24 hours ofter death. Office along with NAME OF 4. DATE Day DECEASED Ellsworth. EROY 19 6 / SIMMS 12 DEATH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7. MARRIED last birthday) 5-10-44 WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Stote or fareign country) during most af warking life, even if retired) U.S. GOVERNMENT COUNTRY? LATOREN HARMONS, MARYLAND 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME This certificate should be executed within SHER MAE File Address BOX 109 PUST Ro 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, arunknawn) (If yes give wor ar dotes of service) 214-40-0383 MR. Charles H. Simus event within HANOVER, MO INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), buriol-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO any Conditions, if any, which gove rise to immediate couse (a), forwarded to DUE TO stating the underlying couse 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X pe 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 3 should 0 cremation, 20f. (City or town) 20d. INJURY OCCURRED 2 20e. PLACE OF INJURY (Home, form, (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Sectory street, office bldg., etc.) Not While of work Inquiry and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy , Inspection deoth resulted from: Natural causes Accident Suicide Undetermined manner Hamicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER moy be re FUNERAL I SIGNATURE DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) 23d. LOCATION (City or Town) 23a. BURIAL CREMATION 0 BURING BURING SAINTS REST CEMETERY HARMONS, ANNE ARUNDAL Charles SIGNATURE VR ATSME 3035 W. North Ave

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE. MARYLAND 21201 16409 CERTIFICATE OF DEATH 16400 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) det o. COUNTY b. COUNTA MARYLAND requires that the death certificate be executed within 24 haurs after c. LENGTH OF STAY IN 1b c. CITY OR TOWN outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits write RURAL and give negrest town e. IS RESIDENCE ON A FARM? OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ELUEDERE NO C 3. NAME OF DATE Middle Don 3 the attending physician and campletely sit permit. Then please remave carbon DECEASED OSED (Type or print) DEATH CEMBE NEVER MARRIED lost birthdoy) and in any WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) INDUSTRY SERVICE PLER 13. FATHER'S NAME or remaval, 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknown) (If yes give wor or dates of service BELVEDERE 1-3055 crematian, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY Myocardial infarction IMMEDIATE CAUSE (o) DUE TO signed l Conditions, if ony, which gove (b) Hypertensive-arter. CVD rise to immediate couse (o), DUE TO stoting the underlying couse as the this certificate has been last. 19. WAS AUTOPS PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO be retained by the haspital ar 20o. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) 20d. INJURY OCCURRED (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work O FUNERAL DIRECTOR: After I fram Oct 1942, 19 ta Dec 7, 1967 that (I) (we) last and that death accurred at 7.304 M, fram causes and an the date stated above. 21. I certify that (1) (this haspital) attended the deceased fram Oct 1942, 19 shauld 1967 saw the deceased alive an Dec 22b. DATE SIGNED 12/9/67 220. SIGNATURE M.D. DIRECTOR PHYS 22c. PHYSICIAN'S Forest Park Ave, Balto Md #7 Kennard Yaffe, M.D. NAME (Type) director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL CREMATION. 23b. DATE THEREOF REMOVAL (Specify) BALTINORE NATIONAL BALTIMORE. 2Sb. REGISTRAR'S SIGNATURE 25a, REC'D BY REGISTRAR VR A15 DATE DEC 20 M 1/66



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rtificate be ex physician and en please rem aval, and in an	10a. USUAL OCCUPATION (Give kind of work done during mast of working life, even if retired) CLERK 10b. KIND OF BUSINESS OF INDUSTRY	GREAT BENE	(OUNTRY?
quires that the death certific physician. signed by the attending physi burial-transit permit. Then pl burial, crematian, ar remaval,	13. FATHER'S NAME Charles HERRICK 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME	+mare
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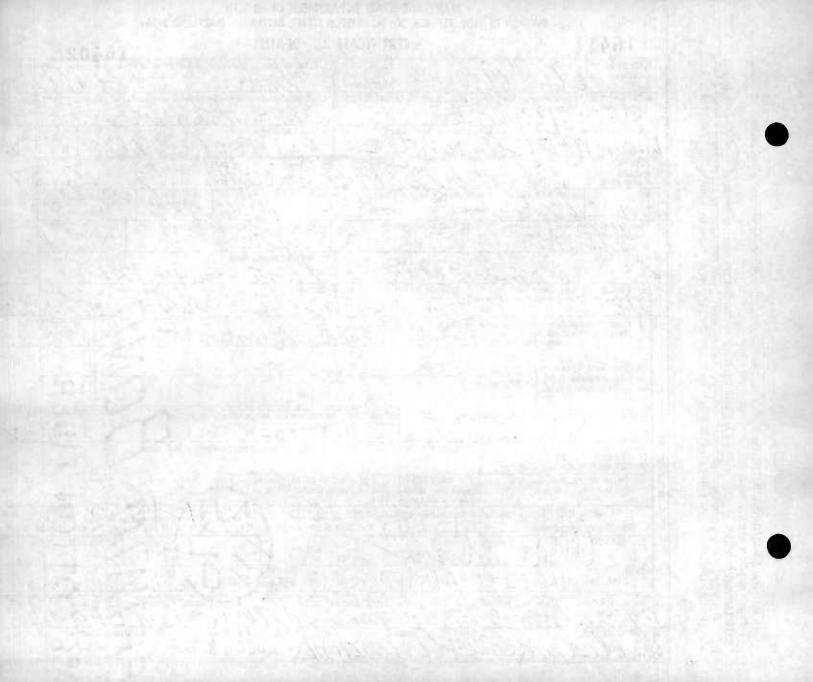
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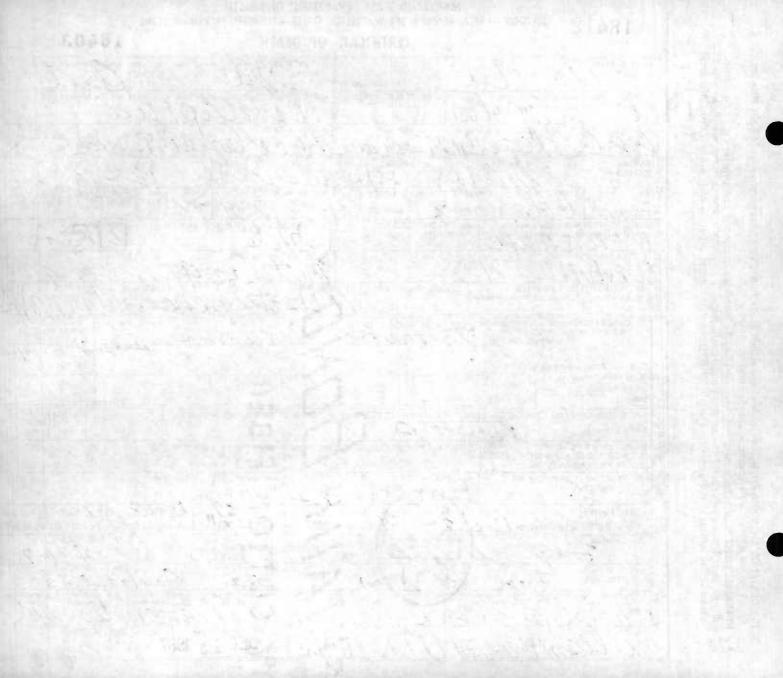
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23o. BURIAL, CREMATION

FUNERAL DIRECTOR.

DATE THEREOF





FOR STATE 16413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1640	
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HEALTH DEPT. I. PLACE OF DEATH o. COUNTY Anne Arundel County MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before o. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) ROWLIGO ROW	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS North Arundel Hospital Box 402 Race Track Road S. NAME OF First Middle Lost 4. DATE Month Doy	IS RESIDENCE ON A FARM? ES NO Year
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deoth resulted from: Naturol couses , Accident X, Suicide , Homicide , Undetermined manner Actual Signature Signature ACTUAL SIGNATURE ACTUA	M. D. in my opinion 2. DATE SIGNED
SIGNATURE EXAMINER'S NAME (Type) SIGNATURE EXAMINER'S NAME (Type) SIGNATURE EXAMINER'S NAME (Type) Fedward F. Wilson, M.D. 230, BURIAL, CREMATION, REMOVAL Checked SIGNATURE LANGE (Type) Address (Street, city, town, or county) December 230, BURIAL, CREMATION, REMOVAL Checked SIGNATURE LANGE LANGE ADDRESS AUXILIARY LANGE	Md.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16415 CERTIFICATE OF DEATH 16406 requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Anne Arundel General Hospital 14 Severn Avenue NO X YES NAME OF Lost 4 DATE Month Dov Year DECEASED Louise TARR Mary Jones December 2 (Type or print) 9 DEATH S. SEX 6. COLOR OR RACE 7 MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED last birthdov) Months Hours WIDOWED K DIVORCED October 9, 1881 Female. White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT please during most of working life, even ifretired) **INDUSTRY** COUNTRY? U. S. Maryland MOMEWI 13. FATHER'S NAME MOTHER'S MAIDEN NAME crematian, or removol, attending phy: permit. Then p WAS DECEASED EVER IN V.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN buriol-tronsit purial, cremati PART I. DEATH WAS CAUSED BY Carcinonia, head of by the hospital or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse detoched for use os the e Dept. of Health prior to hos been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPS PHYSICIAN: The PERFORMED? NO O FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) 21. I certify that (1) (this hospital) attended the deceased fram 12/21, 1967, that (1) (we) last 1967, and that death accurred at saw the deceased alive an M, from couses and on the date stated above 220. SHONATURE 22b. DATE SIGNED M.D. PHYS DIRECTOR PHYS 22d. ADDRESS PHYSICIAN'S NAME (Type) Mouriey director, 23o. BURIAL CREMATION 23b. DATE THEREO! LOCAJION (City or Town) (County) 250 REC'D BY REGISTRA 25b REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16416

the funeral

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after deoth. Page 4 may be retained by the hospital or attending physician.

VR A15 (4) 25M 1/67

CERTIFICATE OF DEATH

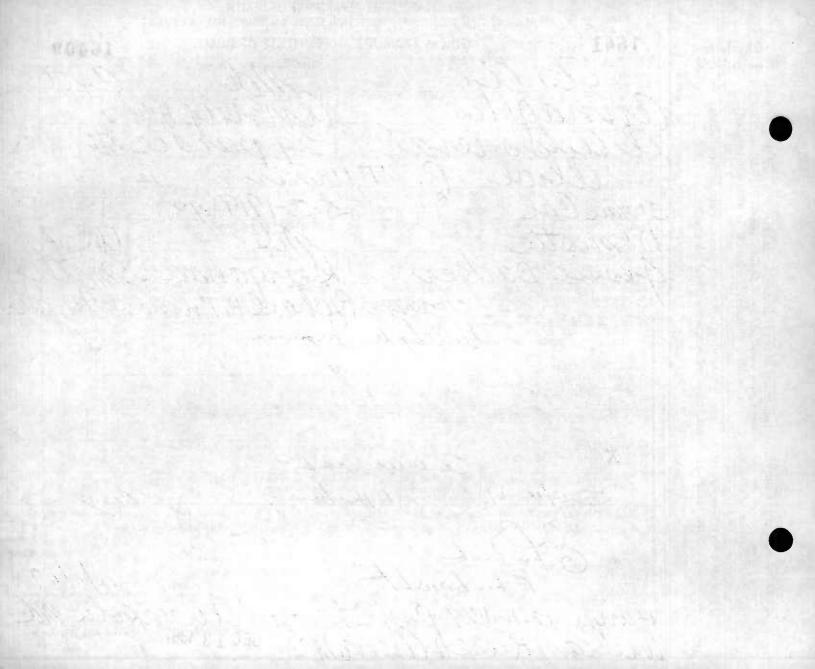
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	PLACE OF DEATH	2. USUAL RESIDENCE Where deceased lived, if institution: Residence be	efore odmission)
	o. COUNTY	o. STATE b. COUNTY	110
	MARYLAND CLENGTH OF STAY IN 1b	c. STY DR TOWN (If outside corporate limits, write RURAL and give nec	
/	C. LENGTH OF STAY IN 1b	c. WIT UK TUWN (IT outside corporate limits, write RUKAL and give ned	orest town)
	1/1/1/CCC) CACC)	(XIMMODHU)	02-1
	d. NAMI OF HOSPITATION (NSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS // //	e. IS RESIDENCE
1	li Ch Denesal	10 College Creek	ON A FARM? YES NO
	NAME OF DECEASED (Type or print) MENU First Single TILE	DEATH 1. DATE Month TO DEATH	Doy Year 1967
SI	X 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X 8	B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEA	
	omale Ole WIDOWED DIVORCED	5-1-1910 Stast birthdoy) Months Day	ys Hours Min.
r	USUAL OCCUPATION (Give kind of work done in the state of	The BURTHPLACE (County & State, or foreign country) 12. CITIZEN COUNTY	TOP WHAT
3.,	EATHER'S NAME	14 MOTHER'S MATDEN NAME	1
1	Candolow Thomas	Rosel Randall	_
	s, no, or unknown) (If yes give wor or dotes of service)	NFORMANT Address Address	200 61
	1213/16/4068 19	achel Danovorococce	efe eft
٦	1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)		INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY:	ombosis due to Arteriosclerotic	ONSET AND DEATH
	720/ DUE TO		
	Conditions, if ony, which gove) (b) Hypertensive Cardi	o Vesculer Disease	l year
	rise to immediate couse (o),	O VASCUIAI DISCASE	ycai
-	storing the underlying couse		
	last. (c)		
CEKIIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO T	HE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO S
5	May ACCIDENT WAS IMPERIATED TO A DESCRIPTION MILLION OCCUPANTS.	Manager and the state of the st	YES NO 3
	206. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. ((Enter noture of injury in Port I or Port II of item 18.)	
	(IF EITHER, NOTIFY MEDICAL EXAMINER)		
MEDICAL		CE OF INJURY (Home, form, 20f. (City or town) (County)	(Stote)
1	Hour o.m. While Not While of work of work	ory, street, office bldg., etc.)	
	21. I certify that (I) (this haspital) attended the deceased from	November 1967 to Dec 10 1967	that (1) (wa) la
	saw the deceased olive an Dec. 10 1967, and that	deoth occurred at 2:30M, from causes and an the c	late stated abov
	220. SIGNATURE	ATTENDING MED CTASS 22b. DATE S	IGNED
	M.D. M.Cal day	D. ATTENDING MED. STAFF DIRECTOR DIRECTOR PHYS. DIRECTOR 12-12-	-67
	22c. PHYSICIAN'S	22d. ADDRESS	
	NAME (Type) R. L. Richardson, M.D.	110 Clay St., Annapolis, Md.,	21401
20			
230	D. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR C	CREMATORY . 23d 20CATION (City or Town) (Cou	inty) (Yang)
2	INMINITE DE LA CONTRACTIONAL	muyer evgen wer	1//
24	FUNERAL DIRECTOR	250. REC'D BY REGISTRAD 25b. REGISTRAR'S SIGNA	
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16417 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE Maryland b. COUNTY Anne Arundel Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Annapolis Life d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENC 4 Bricin St., ON A FARM? and completely filled Anne Arundel General Hospital YES NO K NAME OF Middle 4. DATE **First** Lost bon Month Year DECEASED TROTT December Wesley 67 Alvin event. (Type or print) 19 DEATH S. SEX 6. COLOR OR RACE NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED XX remove birthdoy) Months Dovs Hours White ond in ony Male WIDOWED DIVORCED July 4. 1926 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) signed by the ottending physicion burial-tronsit permit. Then please burial, cremation, or removal, and i INDUSTRY COUNTRYS Anne Arudel, Maryland Construction Plasterer 13. EATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address # 2 (Yes, no, or unknown) (If yes give wor ar dates of service 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE DUE TO Conditions, if ony, which gove (b) rise to immediate couse (o), DUF TO stoting the underlying couse os the has been PHYSICIAN: The law lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0 WAS AUTOPSY CFRTIFICATION PERFORMED? NO be retoined by the hospitol or TO FUNERAL DIRECTOR: After this certificate for 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item IB.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE OF INJURY (Home, form, (County) 20c. TIME OF INJURY Month, Dov. Yeor 20d. INJURY OCCURRED (City or town) (State) foctory, street, office bldg., etc.) Hour a.m. Not While ot wark 21. I certify that (1) PROPERTY) attended the deceased fram Dec. 5. 19 67 that (1) (1) (1) last and Mat death occurred at saw the deceased alive an Dec. 5. 19 67 M, fram causes and on the date stated above 12:10 AM 220. SIGNATU b. DATE SIGNED M.D. DIRECTOR poge 22d. ADDRESS 22c. PHYSICIÁN'S director, po NAME (Type) Peter F. Verkous. M.D. 1407 Forest Drive, Annapolis, Md. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMAJORY (State) 2So. REC'D BY REGISTRAR EUNERAL DIRECTOR REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 DATE DEC 8

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*	FOR STATE		1 C L 1 O MEDICAL EVAMINEDIS CERTIFICATE OF REATH	4.00
	HEALTH DEPT.	1.	PLACE OF DEATH O. COUNTY 2. USUAL RESIDENCE Where Deceosed lived, if institution: Residence of COUNTY D. COUNTY	409 before admission)
	delay is ond 3 to M3. Page		MARYLAND MILLS	neorest town)
	pw3.	1	Controlled of the controlled and	09-1
	5 C 10	1	d MANUSOF HOSPHATJOR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS 290auleste	e. IS RESIDENCE ON A FARM? YES NO
	ofter deoth 8. Give Page olong with t		NAME OF DECEASED (Type or print) PLOSE R. Middle TUNNER OF DEATH 12	Doy Year 19 6-7
	s ofter 18. Giv olong with 1 th.	_	SEX 6. COTOR OR RAFE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 1 9. AGE (In years IF UNDER 1 Y	EAR IF UNDER 24 HRS. Doys Hours Min.
	INER: This certificate should be executed within 24 hours ofter death. If a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, should be forwarded to the Chief Medicol Examiner's Office along with form files. 3 should be used as buriol-transit permit. File pages land 2 with the State De lian, or removal, and in any event within 72 hours offer death.	10a dur		EN OF WHAT
	within 2. pencil in xaminer's ile pages hours off	13.	3 EATHER'S NAME 1 MOTHER'S MAIDEN NAME 1 MOTHER'S MAIDEN NAME 2 DO 1 MOTHER'S MAIDEN NAME 2 DO 1 MOTHER'S MAIDEN NAME	11111
	be executed within "pending" in pencil iief Medicol Examine insit permit. File pag ent within 72 hours o	15/	S/ WAS DECEASED EVER IN U.S. ARM/O FORCES? (es, no, or unknown) [(If yes give wor or dates of service)] Address	Trunk
	e execute pending" ef Medico isit permit		18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
	should be executed to word "pending" is o the Chief Medical burial-transit permit.		PART I. DEATH WAS CAUSED BY: 1 MMEDIATE CAUSE (0) Mulliple Jujunes Due to	ONSET AND DEATH
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	vertificate should writing the word rwarded to the Chensed os a buriol-travel, ond in any ev		storing the underlying couse DUE TO (c)	
	This certificate should cate, writing the word be forwarded to the Cl be used as a burial-transmood, and in any every	HON	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)	19. WAS AUTOPSY PERFORMED? YES NO
	rerificate, ould be for the state of the sta	CERTIFICATION	200. EXTERNAL CAUSE WAS PRIMARY OF OCONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) CAUSE OF DEATH. CAUSE OF DEATH.	7.5 [] 110 []
	INER: 1 the certific should b files. 3 should tion, or r	MEDICAL CE		ty) (Stote)
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	cal EXA execute or. Poge of for you			and in my apinian
	MEDICAL EXA please execute I director. Page retained for you DIRECTOR: Page or to buriol, crem		death resulted from: Natural causes , Accident , Suicide , Hamicide , Undetermined manner CHIEF MEDICAL EXAMINER	
			SIGNATURE SIGNATURE DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEPUT	22. DATE SIGNED
	th New York		NAME (Type) = -LIN SPROS Address (Street, city, town, or county) /2/	11/6/
	TO D the S mr	230	Bo. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR SEMATORY 23d. DOCATION (City or Town)	Sunty) Mich
	VR A15ME (5)	24	11 1 Leam Reese # ADDRESS DATE DER REGISTRAR 1987 Sb. REGISTRARS SAC	Minister



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16419 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) @5 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS Filled YES NO L NAME OF DATE Month Doy Yeor carban 3 DECEASED 12 (Type or print) in any event, DEATH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) 2 yrs. Months Dovs Hours WIDOWED DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY NESTING HOUSE ENG. WRITER 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal. InTOSH 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 307 HASKE burial, crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: neumonia IMMEDIATE CAUSE (o) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. Conditions, if ony, which gove rise to immediate couse (a). DUE TO far use as the l Health priar tak stoting the underlying couse has been ZEAMERS DIS. E CEREBRUL At WAS AUTOPS) PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port | or Port || of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) 1967. to 21. I certify that (\$\sigma\$ (this haspital) attended the deceased fram 1967, that (1) director, page of siled with the 19 67, and that death accurred at 6 29M, from causes and an the date stated above. saw the deceased alive an_ FUNERAL DIRECTOR: 22o. SIGNATURE DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S CROWNSVILLE

23c. NAME OF CEMETERY OR CREMATORY

Glen Haven Memorial

Buria. 9 24. FUNERAL DIRECTOR

23o. BURIAL CREMATION

REMOVAL (Specify)

Kirkley Funeral Home, Glen Burnie, Md.

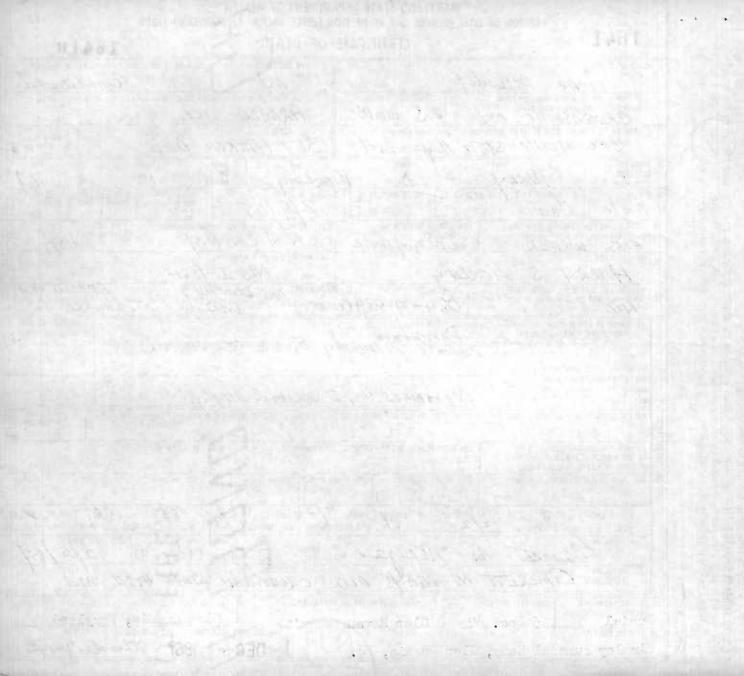
23b. DATE THEREOF

2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 196

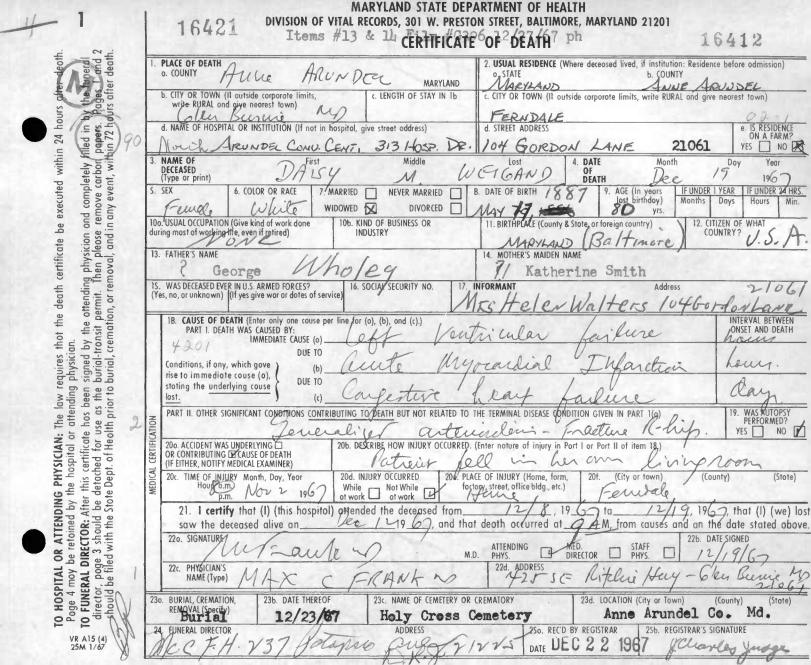
23d. LOCATION (City or Town)

Glen Burnie.

(County)



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	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
i ens	16422 CERTIFICATE OF DEATH 16413
24 hours after death. filled in by the funeral apers. Pages I and and I hours after death.	1. PLACE DF DEATH a. COUNTY Anne Armale MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. STATE MARYLAND b. COUNTY A. A.
ours after in by the Pages hours after	b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) PATAPSCO PARK c. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATAPSCO PARK
24 hour filled in 72 hou	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARMA
y fill pap	221 SHENANDOAH AVENUE 221 SHENANDOAH AVE.
d within mpletel carbon ent, will	3. NAME DF DECEASED (Type or print) ROBERT JAMES WHEELER DEC. 13, 1967
executed within and completely remove carbon promition any event, within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS In the state of the state o
e be e sician lease r and in	10a. USUAL DCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND DF BUSINESS DR INOUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S. A.
ficat phy en p	13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME
ertif ding The remo	JAMES WHEELER ELEENORA?
th c mit.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) 17. INFORMANT Address
dea he a per tion	NO 217-05-7091 FLORENCE GRAY - 77-79 COLUMBIA ST., N. YL 18. CAUSE DF DEATH [Enter only one cause, per line for (a) (b), and (c).]
D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papershould be filed with the State Dept. of Health prior to burial, cramation, or removal, and in any event, within 70 permits the state Dept.	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the DUE TD DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO
law rattendatendatendatendatendatendatendaten	Underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
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PHYSICIAN. The law requir the hospital or attending prints certificate has been detached for use as the bute Dept. of Health prior to bute Dept.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL OISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES ND 20a. ACCIDENT WAS UNDERLYING 20b. OESCRIBE HOW INJURY DCCURREO. (Enter nature of Injury in Part I or Part II of Item 18.) In the significant conditions contributions contributions contributions contributions of the performed pe
NG PHY by the ter this be deta itate De	20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20f. (City or town) 20
TTENDII trained TOR: At should th the S	21. I certify that (I) (this hospital) attended the deceased from 1964, to 13 deceased 1962, that (I) (we) last saw the deceased alive on 1962, and that death occurred at 1964, from the causes and on the date stated above.
AL OR ATTENDING P nay be retained.by th the Directors. After t page 3 should be d filed with the State	22a. SIGNATORE Rendless Library M.D. ATTENDING MEO. STAFF 22b. DATE SIGNED 15 Lee 6 7
ro Hospital, Page 4 may o Funeral director, page should be fill	PHYSICIAN'S NAME (Type) RENOLD B. LIGHSTON, M. D. 22d. ADDRESS 501 CHERRY HILL RD., BALTO., MD.
TO Hag TO Fu dire shou	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE, MARYLAND (State)
V(V) 15 (4)	24 FUNERAL DIRECTOR ADDRESS SO2 MADISON AVE. 252. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE DEC 2 0 1967 Yourseles Years
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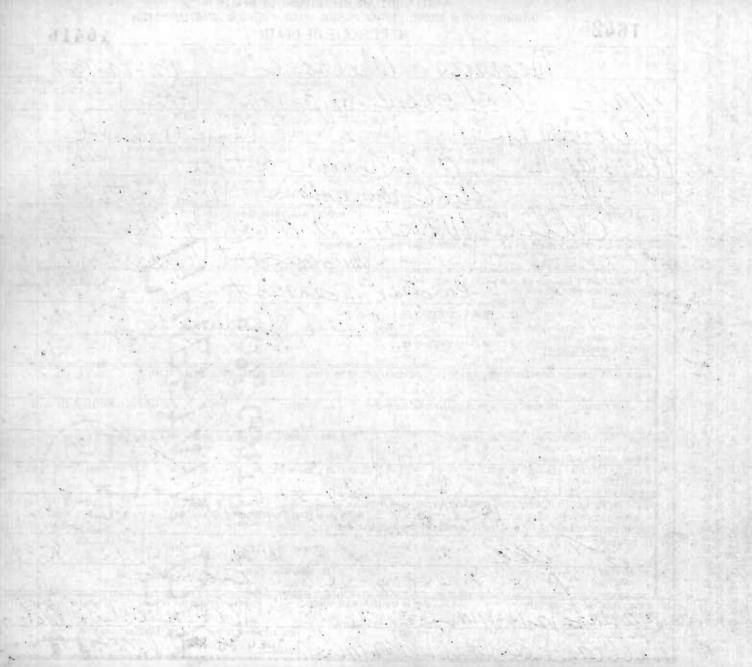
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16423 CERTIFICATE OF DEATH 16414 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY o. STATE MARYLAND Anne Arundel b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street oddress d. STREET ADDRESS e. IS RESIDENCE ON A FARM? filled, YES NO Jones Road 3. NAME OF remove carbon DATE Doy Year DECEASED (Type or print) DEATH S SEX 6. COLOR OR RACE 9. AGE (In years lost birthdoy) IF UNDER YFAR IF UNDER 24 HRS OATE OF BIRTH **NEVER MARRIEO** Months Doys and in ony WIDOWED **OIVORCED** W2910 puo 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired INDUSTRY COUNTRY cremation, or removol, ottending phy permit. Then 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates of service) INTERVAL BETWEEN ONS FAND DEATH 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit i burial, cremati PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' by the hospital or ottending physician DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse be detached for use as the State Dept. of Health prior to hos been lost WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO T TO FUNERAL DIRECTOR: After this certificate 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d. INJURY OCCURREO 20c. TIME OF INJURY Manth, Day, Yeor 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) OR ATTENDING of work 21. I certify that (1) (this hospital) attended the deceased fram 196 7, that (1) (-wet last be retoined and that death accurred at. 25 M, fram causes and an the date stated above saw the deceased alive an 220. SIGNATURI 22b. DATE/SIGNED **ATTENDING** , page 3 be filed v M.D. **OIRECTOR** 22c. PHYSICIAN South NAME (Type) director, 23o. BURIAL, CREMATION, 23b. DATE THEREO 23d. LOCATION (City or Town) REMOVAL (Specify) RIA 24. FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATI VR A15 (4) 25M 1/67 DATE DEC 2 WSONS

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MARYLAND STATE DEPARTMENT OF HEALTH

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2	1		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
			16425 CERTIFICATE OF DEATH 16416
	÷ _ ~ =		ECEASED-NAME First Middle / / Dost 2a. DATE OF DEATH 2b. HOUR
	death.	1	Type or print) Wellson Welson Month Day 1967 M
	- 2	3. \$	Male 4. RACE OLOUED S. DATE OF BIRTH 6. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. In the state of the st
•	24 haurs after ed in the fur pers. Pages 1		BIRTHPLACE (State or Greigh 76. CITIZEN OF WHAT COUNTRY? B. MARRIED NEVER MARRIED 9. COUNTY OF DEATH WIDOWED DIVORCED Md.
	e executed within 24 haurs after and completely filled in by the fremove carban popers. Popes an any event, within 72 trours after the free control of the free control of the free control of the contro	10/	(IT) OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during) nost-the working life, even if retired.) 12. USUAL OCCUPATION (Kind of work dane during) nost-the working life, even if retired.) 12. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during) nost-the working life, even if retired.)
	ompleti ove carl		USUAL RESIDENCE (Where deceased lived, if institution residence before issian) STATE 136. COUNTY Color
	be exe	14.	FATHER'S NAME First Middle Wilson 15. MOTFIER'S MAIDEN NAME First Middle Last
	tificate hysician n pleas val, and		Was DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dales of service) Tob. SOCIAL SECURITY NO. In INFORMANT Maggil Foote to Zwouthant.
	PHYSICIAN: The law requires that the death certificate be executed within le haspital ar attending physician. The certificate has been signed by the attending physician and completely fille stached far use as the burial-transit permit. Then please remove carban pg Dept. af Health priar to burial, crematian, ar remaval, and in any event, within		18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Canditians, if any, which gave)
	aquires that the d physician. signed by the att burial-transit peri burial, crematian.		rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)
	require phys on signe to burio	-	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
	The law attendir has bee as the fit priar if	CERTIFICATION	19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES NO CAUSES OF DEATH?
	JING PHYSICIAN: The law requires by the haspital ar attending physicis. There this certificate has been signed be detached far use as the burial-the State Dept. af Health priar to burial,	MEDICAL CER	21a. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) OR CONTRIBUTING CAUSE OF OFATH, HOUR A.M. Manth Day Year P.M. 19
		ME	21d. INJURY OCCURRED While Not while at wark at wark at wark
	O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 shauld be detached far use as the burial-transpould be filed with the State Dept. af Health priar to burial, cre		220. I certify that (I) (this hospital) attended the deceased fram
	HOSPITAL OR ATTENION OF A THENION OR A THENION OF FUNERAL DIRECTOR: A director, page 3 shauld be filed with the	,	22b. SIGNATURE) DEGREE ATTENDING MED. STAFF 22c. DATE SIGNED 22c.
	Page 4 may O FUNERAL I director, pag		22d. PHYSICIAN'S NAME (Type) A + A L C F Y 22e. ADDRESS Calheles
	TO HOSPI Page 4 m TO FUNER director,	230	BURIAL CREMATION, 23b. DATE 23c. NAME OF CEMETERY OF CREMATORY 23d TOTATION (City or Town) (Rounty) State)
	VR A15 A0 30M REV. 1968	24.	TUNERAL DIRECTOR VILLIAM ROOSE #- UNIG. M.C. DATE LEGISTRAR 256. REGISTRAR'S SIGNATURE DATE LEGISTRAR'S SIGNATURE DATE LEGISTRAR'S SIGNATURE



ages 1 and 2 should thin 24 hours after TO HOSPITAL RATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 death. Page 4 ECTOR: After this certificate has been signed by the attending physician and complete. COMPLEAL ECTOR: After this certificate has been signed by the attending physician and complete. Complete of director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hqursafter of the state of the

	16426	OF STATISTICAL	RESEA	RCH AND RECORDS	5, 301 W. PRES		EET, BALTIMO	RE 1, M	ARYL	AND	
_	10420			CERTIFICAT	E OF DEA	TH			16	417	
1,	PLACE OF DEATH	1	1.11			DENCE (Whe	ore decessed lived, If		esidenc	e before e	dmission)
	Anne Al	Runde1		MARYLAND	e, STATE		b. COUN	ITY		6	
	b. CITY OR TOWN (if outside corporete limits.		c. LENGTH OF STAY IN 16	c. CITY OR TO	WN (If outside	corporete limits, write	RURAL and	give n	eerest tow	n)
13	Laure	give neerest town)		12 yrs.	Washi						
	d. NAME OF HOSPIT	TAL OR INSTITUTION (if	not in hos		d. STREET ADDI	Washington, D. C.					
	Children'	s Center Ho	spit	n 1	233_	12th Pi	lace N E			YES T	NO [.]
3.	NAME OF	First	орто	Middle	Last	4. DA	TE Month	1	Dey	Yeer	
	(Type or print)	Joh	n		Winebren	OF DE	ATH D	,		10	
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	Male		WIDOWE		0 15 40		last birthdey)		Deys	Hours	Min.
10		White		IND OF BUSINESS OR INDUST	9-15-48	County & State	e, or foreign country)	1 12 CITE	7FN OF	WHATC	OLINITAVA
d	one during most of wo	rking life, even if retired)	10011	THE OF BOSINESS ON HUDOS.				12. (111	ZLIN OI	WIIAI C	OOMINII
12	Instituti	onalized			Wash:	ington,	D. C.	U	SA_		
1.3					14. MOTHER'S MAI	IDEN NAME					
15	John P.	Winebrenne	r			Mae Win	ebrenner				
(Y	es, no, or unkown) (I	ER IN U.S. ARMED FORCE	(ice) 16.		INFORMANT		Address				
	No				Children's	Center	Hospital	Laur	el.	Md.	
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	geve rise to immedi (e), steting the u										
	couse fest.) (c)									
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ATI	E	PILEPSY	,						Y	PERFO	NO TH
CERTIFICATION		AS UNDERLYING D	Qb. DES	CRIBE HOW INJURY OCCURE	D. (Enter neture of injur	ry In Pert I or F	Pert II of item 1B.)				
GE	OR CONTRIBUTING	MEDICAL EXAMINER)									
Y	20c. TIME OF INJU	RY Month, Dey, Yeer	20d.		ACE OF INJURY (Home		(City or town)	(Cour	nty)		(Stete)
MEDICAL	Hour a.m.		While		tory, street, office bldg	., etc.)					7.4
Z	p.m.	19	1		- 1						
				ded the deceased from.							
		ed alive onIVOV	emper	30.19,67, and tha	t death occured a	atluw/a	from the causes	and on t	he da		
	220. SIGNATURE	1	1	,, 10	ATTENDING	MED.	STAFF			226.	DATE SIGNED
	22c. PHYSICIAN'S	ccu /	ca	way ,	A.D. PHYS.	DIRECTOR	PHYS.		Dec	. 1,	1967
	NAME (Type)		43770	**					95	1 11	1
_		WILLIAM FR					ter Hospi			er, M	a
23	e. BURIAL, CREMATI REMOVAL (Specify)	ON, 23b. DATE THERE	OF / ws	23c. NAME OF CEMETERY		23d.	LOCATION (City, to	wn or county)	1 A (Sh	A. Co.
1	1 , (1-1-5-1	0/	Cheldren	s Center	0 0	saurel	, ,	no	1.	
1	Thinks Director	SEIGNATURE	110	ADDRESS AM A	25e.	REC'D BY RI	EGISTRAR 25b. REG	100 / 1	, ,	URE 2 CA	
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	16427 CERTIFICATE OF DEATH									6414	
hours after death. d impy the funeral rs. Pages 1 and 2 Z hours after death.	1.	PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. STATE b. COUNTY					
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Sin Day		Glen Bur	nie		14 yrs.		Burnie			02-1	
fired appers		d. NAME OF HOS	PITAL OR INSTITUTIO	N (if not In h	ospital, give street address)	d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?	
			2, Box 451,	Point	Pleasant	Rte. 2, B	ox 451,	Point Pl	easant	YES NO E	
executed within in and completely remove carbon in any event, with	3.	NAME OF DECEASED		rst	Middle	Last	4. DATE OF	Month		ay Year	
rted w compl ve car event,	5.	(Type or print) SEX	6. COLOR OR RACE	les MARRIED	N. NEVER MARRIED	Worthington B. DATE OF BIRTH	19	Dece	FUNDER 1 YEA	RIFUNDER 24 HRS.	
executer and con remove	0	Male	White	WIDOWED		8 May 1877		last birthday)	Months Days		
	10a	USUAL OCCUPAT	ION (Give kind of work	done 10b, K	IND OF BUSINESS OR	11. BIRTHPLACE (C	ounty & State, o	90 yrs. r foreign country)	12. CITIZE	N OF WHAT	
cate be physician please 1al, and in	uui	Carpent	ing life, even if retire Ser	α) 11	Retired	Howard (County.	M.	COUNT		
ficate phy en pl oval,	13.	FATHER'S NAM	E			14. MOTHER'S MAIL	EN NAME				
eath certificate be attending physicia ermit. Then please n, or removal, and	15	Jo	seph E.		ington		Unkno				
death c ne atten permit. tion, or r	(Ye	, no, or unkown)	VER IN U.S. ARMED FO (If yes give war or dates o	RCES? 16.	SOCIAL SECURITY NO. 17.	INFORMANT		Address			
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iw ratend as the as the serior or ior	Z	underlying caus	e last.	(c) \	enuly a	it have so	um	4			
r attratter he la	ATIO	PART II. OTHER S	IGNIFICANTCONDITIO	ONS CONTRIBL	JTING TO DEATH BUT NOT RELA	TED TO THE TERMINAL I	DISEASE COND	ITION GIVEN IN P		PERFORMED?	
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ING PHYSICIAN: The law requires that the death certificate be d by the hospital or attending physician. After this certificate has been signed by the attending physician is defacted for use as the burial-transit permit. Then please state Dept. of Health prior to burial, cremation, or removal, and in	CERTIFICATION	OR CONTRIBUTION (IF EITHER, NOT	NG CAUSE OF DEATIFY MEDICAL EXAMI	TH NER)	DESCRIBE NOW INSORT GOOD	INNED. (Litter nature o.	i injuty in tal	. 1 01 1 011 11 01	110111 10.)		
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JING P d by t After d be d	MEDICAL	Hour a.m		While at worl	- NOT WILLS	ry, street, office bldg., e	tG.)	,			
OR ATTENDING be retained by JIRECTOR: After Is 3 should be sed with the Stat		21. I certify	y that (I) (this hosp	ital) attend	ed the deceased from 9	1/29/64,1		147		that (I) (we) last	
ATTEND retained ECTOR: A 3 should with the			eased alive on	12/8	19.67_, and that	death occurred at	M, from	n the causes a			
OR ATTENI y be retaine DIRECTOR: age 3 should		22a. SIGNATOR	uller VI	1 11	200-1	ATTENDING PHYS.	MED. DIRECTOR	STAFF	22b. DATE	IGNED	
ral or nay be al Dir page page		22c. PHYSICIA	N'S	- 1/-	M.I.	22d. ADDRESS	DIRECTOR	PHYS.			
HOSPITAL OR ATTENDING Page 4 may be retained by FUNERAL DIRECTOR. After director, page 3 should be should be filed with the State		NAME (Ty	G.S.	Linsao,	M. D.	7308 Fur	nace Bra	anch Rd.	Glen B	urnie, Md.	
O HOSPITAL Page 4 may O FUNERAL director, pa	23a.	BURIAL, CREM. REMOVAL (Spe	ATION, 23b. DATE 1		23c. NAME OF CEMETERY		23d. LOC	ATION (City, tov	vn or county)	(State)	
	24	Burial FUNERAL DIRECT	11 De	c. 67	Glen Haven	Memorial 25a, RE	Gle	n Burnie	Mary	land.	
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16419

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to do		PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
9 000		a. COUNTY	Anna Anunda	. 1	o. STATE b. COUNTY							
P 1773			Anne Arunde		MARY		N .	yland				rundel
五五五			f autside carparate limit give nearest town)	is,	c. LENGTH OF STAY I	N Ib	c. CITY OR TOWN (If au	itside carpor	ote limits, write RL	JRAL and giv	ve neorest t	own)
by Paris			napolis				Shei	rwood For	rest		021	
of 6 55		d. NAME OF HOSPITA	AL OR INSTITUTION (If n	at in haspital, giv	ve street address)		d. STREET ADDRESS	91101	11004 101	036	e	IS RESIDENCE ON A FARM?
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filled in Pagers.	-		Arundel (YES	NO X
至 25		NAME OF DECEASED	F	irst	Middle		Last	4. DATE	Mar	nth	Day	Year
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executed with and completely remave carbon any event, with	S.	SEX	6. COLOR OR RACE		NEVER MARRIED	- T	B. DATE OF BIRTH		Q AGE (In years	IF UNDER	1 YEAR IF	UNDER 24 HRS.
a ve				WIDOWED T	DIVORCED			25	last birthday)	Manths	Days	Haurs Min.
and co	10	Male	White				April 3, 190					
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	ION	TAKE II. OTHER SI	AIIII CONDITIONS	- CONTRIBUTION TO	DEATH DOT NOT KEE	110 10	THE TERMINAL DISEASE CON	IDITION OIT	LIN IN TAKE I(U)		PE	AS AUTOPSY REORMED?
AN: That are an are	CERTIFICATION										YES	NO 🗆
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S PHYSICIAN: the haspital ar this certificate detached for u e Dept. af Heal	MEDICAL	20c. TIME OF INJU	RY Month, Day, Year	20d. INJ	URY OCCURRED	20e. PLA	CE OF INJURY (Hame, farm	1. 20f.	(City or town)	(((unty)	(State)
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d A A B S S S S S S S S S S S S S S S S S			y that (I) (this hos	spital) attende			- Typi	966.	0 /0-	6, 19	7'	(I) (we) lost
TE in Section 1			ceosed alive on_	127/8	19. (), c	ind tha	t death occu y red at			and on t	hé dote :	stoted obove.
TA S D S S S		22a. SIGNATURE	100	10	10		ATTENDANC	MED	P.M.	22b. [ATE SIGNED	1-
DIRE DIRE		(MA	and Un	den	hles	M.I.	ATTENDING PHYS.	DIRECTOR	PHYS. C	1/1	-18	- 47
DIR DIR DIR filed		22c PHYSICIAN'S	1	2 11 11	1 -		22d ADDRESS			AL	1	0
TA MA		NAME (Type)	FM-	HIP	LAV		Vinn	no	chil	da	h	-//
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He Be Be C		BURIAL, CREMATIO			23c. NAME OF CEME				CATION (City or To	awn)	(County)	(State)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16430 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If autside carparote limits, write RURAL and give neorest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) papers. hin 72 h d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO [3. NAME OF Middle DATE Manth Day Year campletely carbo DECEASED **OF** (Type or print) and in any event, DEATH 19 S SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH IF UNDER 1 YEAR NEVER MARRIED AGE (In years IF UNDER 24 HRS last birthday) Manths Days Haurs Min WIDOWED DIVORCER and 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) Retired COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, attending physpermit. Then F Frans Disak Ynttimaa Hedvik Serafi Yrttimaa 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1, Box 493 Arnold, Md. 17. INFORMANT (Yes, no, ar unknown) (If yes give war or dates af service) crematian, 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c). icate has been signed by the far use as the burial-transit Health priar to burial, cremai PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) attending physician. DUE TO Conditions, if ony, which gave rise ta immediate couse (a), DUE TO stoting the underlying cause this certificate has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO ATTENDING PHYSICIAN: YES 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 1B.) detached for the details of the deta OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or tawn) (County) (State) Haur a.m. Not While factory, street, affice bldg., etc.) State [ot work TO FUNERAL DIRECTOR: After ot work 21. I certify that (1) (this hospital) attended the deceased fram 1960 19 27, ta. 19___, that (I) (we) last be retained ___, and that deoth accurred at 10 AM; fram causes and on the date stoted above saw the deceased alive on 6719-22a. SIGNATURE 22b. DATE SIGNED DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, shauld b 23a. BURIAL, CREMATION 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) Buria 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Moran Inc.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 16431 CERTIFICATE OF DEATH degiff. requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY es b. CITY OR TOWN (If autside carparate limits. c. LENGTH OF STAY IN 1b limits, write RURAL and give negrest town) write RURAL and give negrest town wince Total. e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give-street address) d STREET ADDRESS NO I within 3. NAME OF Middle 4. DATE Year DECEASED OF DEATH 12 16 1967 (Type or print) 5 SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED DATE OF BIRTH 7 MARRIED last birthdoy) Haurs WIDOWED DIVORCED pup 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10g. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) physicion a COUNTRY 2 during most of working life, even if retired) INDUSTRY Handyman 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAMI Broken Wit Address Jande w 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give war or dates af service) 17. INFORMANT 16. SOCIAL SECURITY NO. burial-tronsit pern burial, cremation, 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Poge 4 moy be retained by the hospital or ottending physicion. DUE TO Conditions, if ony, which gave rise to immediate couse (o), DUE TO stating the underlying couse os the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) be detached for use State Dept. of Health NO TO FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Manth, Dov. Year Haur a.m. factory, street, office bldg., etc.) Not While ot work ot wark ., 1962 that (1) (we) last 21. I certify that (1) (this hospital) attended the deceased from 12/15,1867,10 director, page 3 should should be filed with the 12/15 1967, and that death accurred at 9/3/4M, fram causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICHAN'S NAME (Type) FT. SMALLWOO. 23a. BURIAL CREMATION. 23c. NAME OF CEMETERY OR CREMATOR' 23d. LOCATION (City or Town) (County) REMOVAL (Specify) AUNERAL DIRECTOR 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 DATE DET

